Australian and New Zealand Podiatry Accreditation Council (ANZPAC) response to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

The Australian and New Zealand Podiatry Accreditation Council (ANZPAC) welcomes the opportunity to provide this response to the Discussion Paper on the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professionals.

Introduction and Overview

ANZPAC notes that the Discussion Paper asks key questions related to the governance, accountability and consistency of operation of the accreditation functions covered by the National Registration and Accreditation Scheme (NRAS) in Australia and the capacity of these functions as currently constituted to support the future health care needs of the community.

Our response has been formulated within the three thematic headings highlighted in the Discussion Paper, namely: improving efficiency, relevance and responsiveness and producing the future health workforce. In considering each theme, ANZPAC has considered the available evidence, provided its current approach (and where applicable an example), and suggested areas for improvement.

In providing this submission, ANZPAC takes the opportunity to reiterate its support for any changes that will improve the operation of the NRAS however these changes should not come at the expense of the quality work that is currently performed at a discipline specific level.

ANZPAC further commits to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. In undertaking this role, ANZPAC champions a peer led, quality improvement approach to the accreditation of programs of study. This is in contrast to the model espoused in the United Kingdom, which focuses primarily on regulatory outcomes.

About ANZPAC

In 2010, the Australian and New Zealand Podiatry Accreditation Council was appointed by the Podiatry Board of Australia under the Health Practitioner Regulation National Law Act 2009 (the National Law) as the accreditation authority for podiatry. ANZPAC also carries out accreditation functions for the Podiatrists Board of New Zealand (PBNZ) under the Health Practitioners Competence Assurance Act 2003.

Prior to the introduction of the NRAS, there was a voluntary accreditation process managed by the Australasian Podiatry Council (APodC) however uptake was low as there were no regulatory implications for non-participation.
Based on statistics published by the Podiatry Board of Australia in December 2016¹ there were 4,697 general and specialist registered podiatrists in Australia (March 2012: 3,601), with the majority of registrants practising in either Victoria or New South Wales. Six out of ten registered podiatrists are women, with only 1 in 10 aged 55 or older. Only 1.5% of registered podiatrists have an endorsement for scheduled medicines. Almost all (95%) employed podiatrists work in a clinical role averaging 36.2 hours a week.

Available data from the Australian Government Department of Employment (May 2016)² indicates that demand for podiatrists has increased significantly in recent years, as has supply from university graduates. Underlying demand for the profession is increasing due to the growth and ageing of the population and health factors such as the increasing incidence of type 2 diabetes, renal disease and obesity. Department of Employment projections suggest a 16.7% increase in employment of podiatrists over the five years to 2020. This is well above the average growth of 8.3% for all occupations.

For a number of professions including podiatry, there has been a steady increase in the number of education programs over the past ten years. From a starting position of one program per state, and not all states, there are now 11 education providers providing 20 programs of study that are accredited by ANZPAC.

Response to the discussion paper topics

Improving Efficiency

The Discussion Paper asserts that an efficient accreditation system requires sound and fit-for-purpose processes, which are designed to: reduce complexity and unnecessary duplication; increase clarity and transparency; and reduce cost within the system. Previous reviews of the Scheme have highlighted concerns about both the efficiency and cost effectiveness of current accreditation processes.

Measuring the efficiency and effectiveness of accreditation has been a long debated issue, particularly with regard to hospital, primary care and aged care accreditation in Australia. In a cost analysis of safety and quality accreditation in the Australian health care system for the Australian Commission for Safety and Quality in Health Care³, the authors found that:

- Many of the costs required for compliance with standards would be incurred as part of quality or good practice
- In many instances, accreditation is inseparable from sound risk management and quality management procedures
- The overlap of accreditation processes with quality management and continuous improvement means that it would be difficult to separately identify the costs; some may argue that to do so would run counter to efforts to embed accreditation processes with everyday operations;

The outcomes of this study go someway to underpin ANZPAC’s approach to accreditation, particularly the philosophy that whilst cognisant of its role in regulation, accreditation is a peer led, quality improvement tool used to encourage continuous quality improvement within podiatry programs of study in Australasia.

Consistency and commonality in the development and application of accreditation standards

The ANZPAC Accreditation Standards were most recently reviewed in 2015. This review specifically addressed the requirements of our profession specific schedules with AHPRA namely:

a) Opportunities to increase cross-profession collaboration and innovation with (for example) joint projects with other accreditation entities or the Health Professions Accreditation Councils’ Forum (HPAC Forum);
b) Opportunities for ANZPAC to facilitate and support inter-professional learning in its work; and
c) Opportunities for ANZPAC to encourage use of alternative learning environments, including simulation, where possible.

The Discussion Paper notes that the Health and Care Professions Council (HCPC) in the United Kingdom have demonstrated the potential for shared standards. The HCPC has one set of uniformly presented standards for education providers covering 16 professions and common standards for the requirements for registrants.

Representatives from ANZPAC were recently invited to be observers on a HCPC monitoring visit and observations from this visit highlighted the limitations of a set of uniformly presented standards and in particular, the obvious lack of profession specific input. The role of the standards and the resultant monitoring visit was to assess compliance with minimum standards and were somewhat of a “tick box exercise”, rather than an assessment designed to improve quality and assess strengths and weaknesses.

Although the professional college attended the University at the same time as the HCPC observers, the two groups were kept separate in meetings with staff and students from the University. The professional college focused on quality improvement of the entry-level professional program, but this assessment (and a subsequent written report) did not require the University to respond to any concerns. Additionally, the parallel visits of the professional college and the HCPC lead to considerable duplication of effort by the University.

During the HCPC site visit, there did not appear to be any capacity to raise issues related to the continuous improvement of the program, including most importantly program viability, as these issues were not “anchored” to a particular standard. In our opinion, there was no demonstrable link to explore such issues that are currently permissible under the ANZPAC quality improvement approach to accreditation.

ANZPAC generally agrees that there are opportunities for improving consistency in the development of accreditation standards. ANZPAC further agrees that there is scope to improve the consistency of the structure of standards, content and terminology. However, there are currently no systems or funding in place to drive the development of consistent or common standards framework across the Scheme. The collaboration between Accreditation Councils is possible only because of the positive relationships that have been developed voluntarily between members of the HPAC Forum. A cross-professional funding mechanism to support these initiatives would go some way to achieving common structures that could achieve a great deal (once scaled across the registered professions and programs seeking accreditation).

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AHPRA has issued *Procedures for the development of accreditation standards* however these do not address issues of content in general, and commonality of standards in particular. They do not require collaboration by the developers of standards (accreditation authorities) or collective decision-making by the approvers (National Boards) on common items. In fact, both the construct of the National Law and these procedures further encourage a “siloed model”.

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

ANZPAC is of the view that investing in a thorough review of the *Procedures for the development of standards, codes and guidelines* and aligning the timing at which standards are reviewed, could address the requirements for uniform structure, content and terminology (permitting exceptions to maintain profession specific safety as required).

**Incorporation of decisions of TEQSA/ASQA**

ANZPAC has not sought to formalise an arrangement with TEQSA through a Memorandum of Understanding, although acknowledges a number of other accreditation authorities have done so.

Despite this, ANZPAC does not have any objection to incorporating the decisions of TEQSA/ASQA assessment and accreditations of education providers as part of their own reviews noting that these reviews look at the university as a whole as opposed to program level as undertaken by ANZPAC.

ANZPAC’s Accreditation Standards do ask about TEQSA accreditation (standard A1) and do not seek to replicate these processes. ANZPAC acts very much at the level of the podiatry program, attainment of safe and competent practise in graduates and ultimately protection of the public.

**Cyclic accreditation and risk-based accreditation approaches**

ANZPAC operates a cycle of accreditation and re-accreditation of up to five years and supports the value of a cyclic approach, as does TEQSA because:

> The higher education sector generally sees ‘continuous improvement’ as an integral part of academic quality assurance. Continuous improvement is typically based on an ongoing reflective feedback cycle involving monitoring, review and consequent evidence-based improvements both of courses and of major controls on academic quality such as assessment policies and procedures.  

A cyclic approach to the accreditation and re-accreditation of a program of study enables ANZPAC to evaluate programs of study at a point in time, using multiple data sources including face-to-face interviews. Anecdotally, ANZPAC believes that the richest source of information is obtained at the site visit. There is often time to spend in deep discussion of a particular programs’ approach to delivering a program that is sometimes lost in printed documentation.

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Annually on the anniversary of their accreditation, ANZPAC accredited programs of study are required to submit a monitoring report on a prescribed template. Specifically, this report is required to address any changes that would ordinarily fit ANZPAC’s definition of a ‘major course change’. The Accreditation Committee as reviews these reports and when they are submitted and further information may be requested from the education provider at this time.

As yet, ANZPAC has not codified its approach to risk based accreditation in policy. ANZPAC’s role is to ensure that all podiatry programs of study are meeting the ANZPAC Accreditation Standards. It does this through monitoring of programs of study and a course accreditation/re-accreditation process that inherently demands a level of risk assessment by education providers.

Through these processes, which recur up to every five years, ANZPAC considers the provider’s track record and applies a range of assessment methods to reach satisfaction that providers meet and continue to meet, the ANZPAC accreditation standards.

In carrying out its role, ANZPAC’s approach is underpinned by the objectives and guiding principles of the National Law and specifically to:

a) Provide for the protection of the public by ensuring by ensuring that only health practitioners that are suitably trained and qualified to practise in a competent and ethical manner are registered; and
b) Facilitate the provision of high quality education and training of health practitioners

Arriving at a point of confidence in a provider is an important consideration for ANZPAC. Confidence about a provider’s capacity and demonstrated willingness to meet standards and to deal with quality issues as a when they arise is fundamental.

ANZPAC’s confidence in these matters supports its decisions to grant accreditation and renew these decisions on an ongoing basis. ANZPAC has not adopted an approach, which predetermines that particular types of providers are subject to a different treatment. Rather, similar to TEQSA, it has designed its approach and processes to allow it to make nuanced judgements on the scope and depth of monitoring and assessment activities.

**Training and readiness of assessment panels**

Peer review in accreditation is based on the fundamental assumption that quality in higher education is best served through a process that enables peers of the provider, informed by standards created and applied by professionals in higher education, to make the judgements essential to assuring and advancing the quality of higher learning. Peer review means bringing judgement based on experience and knowledge to the evaluation process – from setting the standards, to conducting the evaluation, to making final decisions. In all evaluation processes, judgement, reason, and the documentation of evidence contribute to effective peer review.

A systematic review was completed for the Australian Commission on Safety and Quality in Health Care in June 2009\(^7\) to identify the published literature on peer review to describe the methods being used and assesses their effectiveness. This analysis identified a number of features that increase the rigour of the peer review process:

• The positive predictive value of the peer review increased with a greater number of reviewers however, it is not possible to nominate an optimal number of peer reviewers required for the peer review. Too few reviewers may reduce the reliability of the outcome while too many reviewers has resource implications
• The reliability of the peer review improves when the evidence base for the [clinical conditions] under review is well developed
• Reliability of the peer review process was greater when well-designed structured assessment methods were used, compared with unstructured processes. The addition of structured assessment tools, in particular surveys and checklists, increased the reliability of peer review between assessors
• The exact relationship between quality of peer review and training requirements of peer reviewers remains to be defined

It is worth noting that the policies adopted by ANZPAC for the training, readiness and size of assessment teams is not dissimilar to those policies adopted by other accrediting organisations in the health care space including the International Society for Quality in Health Care (ISQua)\(^8\), the Australian Council on Healthcare Standards\(^9\), AGPAL\(^10\) and the Australian Aged Care Quality Agency\(^11\).

At the heart of ANZPAC are the accreditation assessors. Their role is to validate an organisation’s self-assessment and independently assess their level of achievement, supporting this assessment with a written report containing clear and specific findings, commenting on strengths, areas of best practice, and identifying improvements that can be made to further comply with ANZPAC Accreditation Standards and drive improvements in the quality and safety of the program of study being provided.

ANZPAC currently uses up to four assessors on all of its assessment teams. These are comprised of a senior academic from an accredited provider in another State/Territory (or New Zealand), who has a sound knowledge of podiatry education and an understanding of accreditation processes. The other members include a member of the ANZPAC Board of Directors, a professional body representative and a registered podiatrist. The Team Leader is selected based on their academic and accreditation experience.

The ANZPAC Executive Officer will generally accompany the assessment team on the site visit and participate in any other meetings convened in connection with an accreditation.

Team members are expected to work effectively and expeditiously as a team, use multiple evaluation tools effectively, have in-depth knowledge of the relevant ANZPAC Accreditation Standards and their application, and be professional in all aspects of their work.

Individuals should possess:
• Demonstrated expertise in the field of academic leadership, professional education, research and clinical practice;
• Business management, and/or evaluation skills, such as the interpretation of quantified data, interviewing and observation techniques, and analysis of written information;
• Good writing skills, including the ability to convey clearly and concisely observations and judgments in writing;
• The ability to make unbiased professional judgments about education based on the application of the standards;

\(^8\) Further information available from www.isqua.org
\(^9\) Further information available from www.achs.org.au
\(^10\) Further information available from www.agpal.com.au
\(^11\) Further information available from www.aacqa.gov.au
• Good interpersonal skills, including the ability to interact with team members and Education Provider personnel in a courteous and collegial manner and the ability to work toward consensus in team deliberations;
• Word processing skills and proficiency with common computing software; and
• The capacity to work quickly and efficiently within strict timeframes.

Team leaders are expected to:

• Have a record of high performance and leadership skills
• Have a thorough understanding of the ANZPAC processes and standards;
• Be able to assist less experienced team members;
• Conscientiously follow ANZPAC guidelines and timelines;
• Ask questions when uncertain and keep in touch with the Accreditation Committee when problems arise;
• Be quietly authoritative and exercise leadership without being overbearing or inflexible;
• Be willing to hear all sides yet able to keep discussions focused; and
• Be organised, and able to coordinate activities and meet given timeframes.

Set accreditation fees were introduced from 1 January 2015 and as a result of a comprehensive analysis of professional services and expense claims submitted by accreditation assessors between 2010 and 2014. ANZPAC pays assessment team members a capped rate of $3,500 (ex GST) (for accreditation of new and existing programs of study) and team leaders a capped rate of $8,500 (ex GST) (for accreditation of new programs of study) and $6,000 (ex GST) (for accreditation of existing programs of study).

These honoraria cover a preparatory one-day team meeting, a two-day site visit and other analysis and reporting tasks, which typically equate to 5 days of work for an assessment team member. In comparison to other team members, team leaders are paid an additional fee in recognition of their additional responsibility to review and collate the reports prepared by the other panel members and prepare the final report (an additional 5 days). For a team member, this is comparable to the TEQSA daily rate of $621 (ex GST), which would indicate a fee of $3,105 and team leaders $6,210 for the allocated time.

All assessors are provided with a Handbook for Accreditation Assessment Teams (version 2.0 November 2015) and provided with a telephone induction with the ANZPAC Executive Officer and Team Leader. The Team Leader will act as a mentor to any new assessor(s) on an accreditation.

ANZPAC is happy to support common training for assessment teams to enhance cross-professional collaboration but notes that the limited available literature does not support this as necessarily the best investment to ensure efficiency and consistency.

Face to face training of assessors facilitated by ANZPAC or another accreditation authority is cost prohibitive to ANZPAC, given the number of assessors currently known to ANZPAC (approximately 30). Therefore, ANZPAC is in the process of developing online training modules based on the structure and content of training currently provided by the Australian Pharmacy Council aimed at “new” assessors as well as more experienced assessors. Assessment team members are also provided with standardised templates to support uniform and reliable accreditation assessments.
Example 1:

**Multidisciplinary Accreditation Assessment Team: Podiatric Surgery**

The Accreditation Procedures for Podiatric Surgery Programs of Study (June 2012) prescribe that the assessment team shall be comprised of five persons, one of whom must be an experienced assessor in specialist accreditation and another surgical related specialist representative from a medical or dental discipline. When ANZPAC accredited the podiatric surgery programs of study offered by the University of Western Australia and the Australasian College of Podiatric Surgery in 2015, it worked with both the Australian Medical Council and the Australian Dental Council to source suitable appointments to the assessment team.

ANZPAC was fortunate to attract two quality assessors from both Councils with significant experience in accrediting specialist (in particular, surgical) programs of study. These assessors fully participated in the process and both reported that it was positive experience not only in being part of an accreditation of another profession, but as a useful opportunity to informally compare accreditation processes to ultimately achieve the same outcome.

**Involvement of consumers in assessment teams**

A study by Hinchcliff et al in 2012\(^{12}\) critically examined stakeholder views of the role of consumers within Australian health service accreditation programs. Detailed analysis revealed four main areas of involvement: standards development, patient satisfaction measures within standards, membership of accreditation agency management groups and the role of consumer surveys.

The study found that stakeholders generally believed the role of consumers within accreditation programs is increasing. Views of consumer involvement were positioned on a continuum ranging from ‘promoting meaningful democratisation’ to ‘exemplifying cynical tokenism’.

The study concluded that there are residual questions to be answered concerning the relative value of different methods through which consumer participation within accreditation programs can be achieved in order to provide maximum potential benefit.

On this platform, ANZPAC regards consumer involvement in accreditation functions as essential. We recognise that students, graduates and employers are the main “consumers” of programs of study, with the public the main beneficiary of good training. Other “consumers” of our service include regulators, registered podiatrists and government. ANZPAC involves all of these groups when it develops and reviews its accreditation standards and when undertaking an accreditation of a new or existing program of study.

The ANZPAC Constitution provides that the Board shall comprise “at least two people appointed by the Directors on the ground that such persons posses particular skills, experience or expertise required by the Board from time to time (at least one of whom must not be a podiatrist).” Further, the Terms of Reference for both the Accreditation and Qualifications and Skills Assessment Committees stipulate that at least one Member of each committee must be a community representative.

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\(^{12}\) Hinchcliff R et al Consumer Involvement in Accreditation: Democratisation or tokenism in healthcare? Presented to the AAQHC Conference 2012 available from https://www.ivvy.com/event/FDHYLT/abstract/request
As part of an accreditation site visit, interviews are conducted with a sample of clinical staff in relation to the provision of clinical education, facilities and capacity, senior management and other academic staff in relation to assessment of resourcing and students and/or graduates for the purpose of determining satisfaction with the educational program.

These mechanisms offer multiple points for consumer engagement at a lower cost than having one consumer representative appointed to every assessment team. The incremental cost of a consumer on every accreditation assessment team ($3.5K plus expenses) would need to be passed on to the education provider. It would be a substantial additional cost for no apparent benefit. ANZPAC is confident that the consumer views are addressed within our accreditation standards and accreditation processes.

**Key principles for setting fees and levies for the accreditation function**

The guiding principles of the National Law establishes a basic framework for considering cost and funding issues, providing:

- The scheme is to operate in a transparent, accountable, efficient, effective and fair way; and
- Fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme.

In the previously referenced report on the Cost Analysis of Safety and Quality Accreditation in the Health Care System to the Australian Commission for Safety and Quality in Health Care, the author concluded that:

> While some broad elements of the cost of accreditation have been established, definitive data as to the cost impact cannot be obtained…in the absence of specific costing system capable of identifying those elements of cost related to accreditation, reliable and relevant data cannot be obtained.

Further:

> It is evident that accreditation involves a range of costs. Some of these costs are clearly only attributable to accreditation. Other costs may relate to activities, which are partly done for accreditation and partly for another purpose, for example, general quality activities, risk management, regulatory requirements, and business operations or best practice.

ANZPAC has four limited income streams, namely funding from the Podiatry Board of Australia (through an agreement negotiated annually with AHPRA), the Podiatrists Board of New Zealand, education providers for the accreditation function and assessment fees paid by overseas qualified practitioners seeking registration and/or migration in Australia or Australian graduates seeking to re-enter the profession after an extended leave of absence. As ANZPAC does not charge an annual fee to education providers, income from this source and overseas-qualified practitioners can be highly volatile, and dependent on Commonwealth policy directives (a most recent example being the abolishment of the 457 visa scheme) and the annual work plan.
ANZPAC is of the view that fees charged should be used to fund the related accreditation function, rather than subsidising another function. For example, assessment fees paid by overseas-qualified practitioners seeking registration in Australia should contribute to funding the assessment process rather than being used for other functions such as accrediting Australian programs of study. Similarly, fees paid by education providers should fund the accreditation process rather than being used for other functions such as advising the Podiatry Board of Australia.

Fees for assessing overseas-qualified practitioners may include a component to cover the reasonable direct and indirect costs of developing and maintaining the assessment process. National Board/AHPRA funding will contribute a proportion of the governance and infrastructure costs related to assigned accreditation functions under the National Law.

As demonstrated in the recent report of the Costings Working Group\(^{13}\) of the independent accreditation authorities, over three years ANZPAC has consistently received the least amount of income from a National Board for accreditation functions and also received the least income from “other sources”. Compared to a “like” organisation such as the Optometry Council of Australia and New Zealand (OCANZ) who ANZPAC recently undertook a benchmarking exercise with, ANZPAC receives on average $124,000 less funding from its National Board than OCANZ.

In the absence of a uniform policy across the NRAS, ANZPAC’s policy is to set fees at a level of cost recovery with a minimal administrative overhead to ensure continuous improvement of our systems and processes.

**Relevance and responsiveness**

The Discussion Paper asserts that a greater focus on broader workforce priorities and the outcomes of health education programs, both in professional competency frameworks and accreditation standards, has the potential to streamline accreditation processes and encourage innovation in health workforce reform.

National competition law policy requires that accreditation processes attend to program quality and be “agnostic” on the question of supply of health professionals, especially in the absence of an agreed national health workforce policy.

ANZPAC will not comment on the desirability or otherwise of a new podiatry program of study except to the extent that it has a legitimate concern for the overall standards of podiatric education or evaluate the workforce implications of a proposal for a new program or school. These principles are consistent with the view that education providers are market facing and make their own program investment decisions.

**Input and outcome based accreditation standards**

Dr Susan Kearn, writing for the Royal Australian College of Medical Administrators (RACMA)\(^{14}\), has asserted that there is much debate in the literature about the types of standards that should be developed. Should they be input, process or outcome standards? Likewise, should they be threshold standards (minimum or compliance based) or should providers be challenged with best practice/aspirational standards?

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\(^{14}\) Kearn S Establishing accreditation and standards in Australia 2011 available from www.racma.edu.au
Input or process based standards have been criticised for restricting innovation with providers seeking only to meet minimum standards. Conversely, outcome based standards will potentially mask critical process flaws that could materialise at some future point in time.

Similarly, should standards describe a static situation, or should they have an improvement focus? Increasingly, there appears to be an expectation that a balance will be struck between a compliance-based approach (for example, HCPC) and an approach that challenges providers to continuously improve their performance level. Program accreditation is both a structure and a process that demonstrates a measure of public accountability that graduates have mastered a baseline set of knowledge and skills in order to function as competent practitioners.

ANZPAC has adopted predominantly outcome based accreditation standards, which do not specify how learning outcomes are to be achieved in podiatry, with little prescription about inputs or processes. This had led to the following examples of flexible design within accredited programs of study in Australia:

- Entry-level programs at different levels of qualification (Bachelor, Bachelor with Honours, Bachelor/Masters combined degrees, Extended-scope Masters, Graduate Entry Masters and a Specialist college qualification for podiatric surgery)
- Programs designed for entry both by school leavers and first degree holders
- Course length has varied to meet specific learning objectives (courses range from 2 years to 4.5 years, dependent in part on prior qualifications or prerequisites for entry)
- Wide variation in the way in which clinical training is delivered to ensure work readiness. Historically, the training of podiatry students was completed predominantly at on-campus clinics offering limited interaction with other health professionals. Clinical practice now involves training at on-campus clinics (not all providers), placement in public health agencies (including hospitals and community health agencies), placement in private podiatry practices and overseas placements
- Variable curriculum/structure/methods of theoretical and clinical teaching, including the timing, nature and volume of simulated learning environments.

**Responsibility for professional competency frameworks**

Since 2010, the development of professional competency frameworks has been the responsibility of ANZPAC. Prior to that, the APodC took responsibility for the development of competency standards

Internationally in podiatry there is no single arrangement in place for the development of professional competencies that spans across countries.

**Interprofessional education, training and practice**

ANZPAC is a signatory to the 2015 HPAC Forum position statement on interprofessional learning\(^\text{15}\). The ANZPAC Accreditation Standards include a requirement that principles of interprofessional learning and practice are embedded in the program of study. We neither limit cross-professional opportunities not inhibit workforce innovation rather contend that the ANZPAC Accreditation Standards foster such innovation.

\(^{15}\) Available from www.healthprofessionscouncils.org.au/statements-and-submissions
Clinical experience and student placements

Contemporary education practices (such as simulation-based education and training) are already broadly embedded in the curricula and clinical experience of all accredited podiatry programs of study.

In a Health Workforce Australia (2014) scoping project that audited practices in SLE across Australian podiatry programs\(^\text{16}\), all used part-task trainer devices for tasks such as injection simulation. All programs agreed that a range of further SLE activities could assist students gain entry-level competencies, and agreed that SLE could be further utilised, particularly in areas of practice for which it is difficult to obtain experience.

Example 2:

Example of clinical experience and student placement

At the University of South Australia, cultural competence is integrated within the program at first, third and fourth year levels. Introductory teaching of cultural issues in regard to Aboriginal and Torres Strait Islander peoples is undertaken in first year. This is followed up in third year and fourth year with cultural awareness sessions with Aboriginal Health workers employed by collaborating services and teaching on communication issues specifically relating to delivery of podiatry services and education strategies.

All students undertake at least one series of outreach clinics at an Aboriginal Community Health Service in their third or fourth year. This exposure involves working with Aboriginal Health Workers, clients and other staff in community clinics while providing podiatry services. At this education provider’s most recent accreditation site visit, students regarded these placements as a highlight of their clinical experience.

National examinations

Anecdotally it has been suggested that there is inconsistency in the knowledge and skills of graduates from different providers offering entry-level podiatry programs in Australasia. Some of the regulated health professions in Australia (e.g. pharmacy) attempt to address this issue by having either standardised final (or ‘capstone’) examinations for final-year entry-level program students, or compulsory examinations for all overseas-trained practitioners. Such assessments purport to ensure that students have achieved the full range of entry-level competencies, and that there is a consistency in the entry-level competency acquisition across all programs in Australia.

However, others would argue that a valid and reliable representation of student competence is better gained through longitudinal, multi-dimensional assessments, where basic skills and core knowledge can be evaluated alongside more complex competency constructs, including interpersonal skills, professionalism, context of care considerations and integration of knowledge into practice.

Recognising there are divergent opinions in the podiatry profession, ANZPAC is not currently persuaded that a national examination is a useful way to determine the educational quality of a program of study. National examinations tend to skew aspects of educational design to meet the exam requirements, rather than to develop overall outcome based competency throughout the full duration of the program of study.

\(^{16}\) Health Workforce Australia National Simulation Learning Project: Report for Podiatry October 2012
There is no evidence in podiatry that ANZPAC is aware of that a national assessment process allows for a more streamlined accreditation process nor that it justifies the investment required for this to be developed and implemented for the podiatry profession in Australia.

**Producing the future health workforce**

The Discussion Paper asserts that best practice regulatory regimes separate the policy advice and direction function from the independent regulator or the body that administers the policy. Activities performed by accreditation authorities are part of the regulatory framework, and the regulator’s governance and accountability arrangements should ensure that all decisions and activities are objective, impartial, consistent, expert and transparent. Meeting these expectations includes addressing both reality and perception as cornerstones of gaining public confidence.

**Governance of accreditation authorities**

ANZPAC agrees with principles that have been previously articulated by the HPAC Forum and the World Health Organisation/World Federation of Medical Education Guidelines for Accreditation of Basic Medical Education (2005) that “the legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession”\(^{17}\).

ANZPAC is registered with the Australian Securities and Investments Commission (ASIC) as a company limited by guarantee and is also a registered charity with the Australian Charities and Not for Profits Commission (ACNC). As a registered charity, ANZPAC must continually demonstrate its commitment to the public interest with this codified within the organisation’s constitutional objects.

Further, ANZPAC must demonstrate compliance with ACNC governance standards and where applicable, corporations law. This corporate structure was favoured by AHPRA and even encouraged as ANZPAC transitioned from an incorporated association in South Australia to a company limited by guarantee.

ANZPAC does not believe that its corporate structure impairs a director’s obligation to discharge their duty and at the same time, fulfil their contractual obligations to AHPRA by virtue of the fact that these obligations are mirrored in the company’s constitution.

Further, ANZPAC does not believe the corporate structure needs to be changed to allow professional expertise to be sourced without creating real or perceived conflict of interest. Management of conflicts of interest is an ACNC governance standard. Conflicts of interest, both under this governance standard and corporation law are allowed to exist. The focus is on how these conflicts are managed and ANZPAC has a robust policy in place to ensure any real or perceived conflict of interest is managed in line with contemporary corporate governance principles.

ANZPAC notes that the Discussion Paper refers to the 2005 Productivity Commission Review that recommended amalgamation of accreditation functions with a single national health accreditation agency to optimise efficiency, improve workforce flexibility and course accreditation consistency, and enhance cross-profession education and training. This was rejected at the time for a range of reasons.

\(^{17}\) Available from wfme.org/accreditation
The Discussion Paper also references the multi-profession regulator, HCPC, in the United Kingdom, which carries out both regulation and accreditation functions for a range of health professions – a number of which are unregulated in Australia - plus the Australian regulated health professions of occupational therapy, podiatry, physiotherapy and psychology.

The paper notes that the HCPC does not have coverage over most of the health professions governed by the NRAS (optometry, chiropractic, dentistry, medicine, nursing, osteopathy and pharmacy), which are subject to profession specific regulation but oversight by the Professional Standards Authority. In reality, HCPC is not a regulator of high-risk professions.

In particular, ANZPAC again notes that the HCPC is focused on the regulation of minimum standards rather than innovation or workforce reform. For this reason, social work is currently being removed from the auspices of the HCPC to create a separate, independent regular for that profession focussed on combining the regulation and improvement functions as a multi-professional model is ‘unable to focus on driving-up standards in social work, focus enough attention in qualifying social work education, and because social work lacks a professional college to lead on improvement’.18

ANZPAC does not consider that there is sufficient evidence for fundamental reform of the governance of accreditation authorities.

**Assessment of overseas trained podiatrists**

The purpose of assessment processes for overseas trained podiatrists is to ensure that they have the qualifications, knowledge and skills required such that they enter the profession at a comparable level to recent graduates from an Australian podiatry program of study. Until the mid 1990s, overseas trained podiatrists applied to a Commonwealth Government body, the National Office for Overseas Skills Recognition (NOOSR) to work in Australia. From 1994, the professional association – APodC - was the gazetted organisation responsible for assessing overseas qualifications. The role transferred to ANZPAC on its incorporation in 2009.

Assessment of overseas trained professionals for registration and overseas trained professionals for migration purposes are separate though aligned issues. The skills for overseas trained professionals are assessed for migration purposes against what is expected of entry-level Australian graduates considering educational qualifications, professional knowledge and English language skills.

The current process is adapted from that originally developed in the mid-1990s with the aim to provide a nationally consistent process across all states and territories in Australia and also alignment with New Zealand with the Trans Tasman agreement. Three key aspects may be involved: qualifications eligibility documentation audit, written examination and clinical practical examination.

Within the past ten years or so, applicants with qualifications from an approved list of overseas programs (approximately 94% of applicants are from programs of study offered in the United Kingdom) have frequently been exempted from the written and/or clinical practical examinations. To the extent that a high number of applicants were exempt from the written and clinical practical examinations, the written examination was abolished and only applicants who cannot demonstrate professional practice over a 3-year period prior to application are required to undertake a clinical practical examination.

18 Quoted in HCPC presentation by Anna van der Gaag (Former Chair) and Michael Guthrie (Director of Policy and Standards) to HPAC Forum meeting 23 September 2016
ANZPAC is of the view that a common assessment process for overseas health practitioners is neither feasible nor desirable because there are too many profession specific competencies, which need to be assessed.

ANZPAC has not had its process externally evaluated as have some professions (including osteopathy and optometry). ANZPAC constantly reviews and refines the process to ensure that it consistently reflects best practice.

In our experience, the current process of individually examining overseas trained podiatrists against the Australian and New Zealand competency standards for entry-level podiatry practice is working well to assure public safety with no identified notifications to the Podiatry Board of Australia specifically from applicants who have undergone this process (noting the limitations of extracting such data from AHPRA).

**Trans Tasman Governance Arrangements**

In addition to the direct benefits attained through the accreditation functions exercised in Australia, there are indirect benefits from activities conducted by ANZPAC outside Australia. Under the Trans-Tasman Mutual Recognition (TTMR) arrangement, any person registered in Australia to practise an occupation is entitled to practise an equivalent occupation in New Zealand, and vice versa, without the need for further testing or examination. Further, when the Health Practitioners Competence Act was introduced, there was strong support for collaboration between Australia and New Zealand with respect to accreditation functions.

ANZPAC carries out both the accreditation and assessment of overseas-trained podiatrist functions on behalf of the Podiatrists Board of New Zealand, apply the same accreditation standards (with minor edits to accommodate cultural differences) and process across Australia and New Zealand.