May 2017

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

Submission to the Discussion Paper
Chiropractors’ Association of Australia

The Chiropractors’ Association of Australia (CAA) is the peak body representing the interests of Australian chiropractors and their patients. The CAA is a national organisation with state and territory branches. The CAA has over 3,000 members (including chiropractic students). Presently, forty six percent of all registered chiropractors in Australia are members of the CAA. The Association is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.
1. **What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?**

Without greater consistency and commonality in the development and application of accreditation standards, the focus of Accrediting Authorities is for the most part exclusively discipline specific. This can make it difficult to accommodate multidisciplinary education and training or to coordinate multidisciplinary accreditation processes to any great extent.

In Australia, the Council on Chiropractic Education Australasia (CCEA) Ltd is an independent, nationally and internationally recognised body responsible for ensuring competency and high education standards in chiropractic for the Australasian community.

CCEA recently underwent an extensive consultation and review of its standards and competencies. The new standards are based on other contemporary and evidence-based Standards, particularly those adopted by the Australian Dental Council. They were also developed with the aim of maintaining equivalence with other international standards.

Finally, we understand that the Council on Chiropractic Education Australasia, Optometry Council of Australia and New Zealand (OCANZ) and the Occupational Therapy Council Ltd recently commenced a joint project that aims to develop a common risk-based framework for use within the accreditation processes of the three Councils which may include streamlining of various processes and formats.

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?**

We would support this where these overlap. We understand the Council on Chiropractic Education Australasia (CCEA) Ltd already incorporates TEQSA/ASQA decisions in their assessments (commencing this in 2017).

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

No comment.

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 cross-professional collaboration?**

The CAA would support a broader range of stakeholders to draw from when recruiting or selecting assessment team candidates, including consumer representatives. Sharing assessment team members across more than one accreditation council may also lead to increased efficiency, consistency and cross-professional collaboration. Particularly for members recruited specifically for their skills or experience as a consumer representative, employer or health facility manager, rather than a member recruited for their profession-specific knowledge and experience.

5. **Should the assessment teams include a broader range of stakeholders, such as consumers?**
The CAA would support a broader range of stakeholders to draw from when recruiting or selecting assessment team candidates, including consumers. We understand the Council on Chiropractic Education Australasia (CCEA) includes community members on its Board and Accreditation Committee and generally includes one non-chiropractic member on each assessment team, usually with an education or administrative background.

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?**

   a) The cost efficiency and efficacy of accreditation authorities should be fostered as far as possible;
   
   b) the direct cost of accrediting programs should be met by education providers;
   
   c) additional funding for accreditation authorities should be met from registrant fees

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 onshore programs?**

The CAA is not opposed to fees being charged for the assessment of overseas qualified practitioners and/or assessment of offshore competent authorities to cross-subsidise the accreditation functions for onshore programs.

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

   In 2016, the Council on Chiropractic Education Australasia undertook an extensive consultation and review of its standards and competencies. The new standards are based on other contemporary and evidence-based Standards, particularly those adopted by the Australian Dental Council. They were also developed with the aim of maintaining equivalence with other international standards. The new standards are outcome-based and were developed to help facilitate workforce innovation.

   Nevertheless, we believe both input and outcome-based standards are necessary for assessment of a provider and accreditation of a program to both maintain teaching and learning standards and minimise risk.

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

   See our answer to question 8.

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 CAA would cautiously support a common approach to the development of professional competency frameworks and to the inclusion of consumers and others (i.e. employers) in that
development. This is particularly relevant in domains such as communication, ethical behaviour, leadership and collaboration as identified in the Accreditation Review discussion paper.

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

**Advantages**

- Assist inter-professional education and learning particularly at institutions running more than one professional program.
- This should also help promote collaboration between professions, enhancing team based care.
- In the long term this should make the accreditation process across different professions and educational institutions cheaper and more efficient.

**Disadvantages**

- Short term this will add additional costs to the accreditation process as new accreditation standards are developed and then implemented.
- There is a risk that ‘one size fits all’ or common accreditation standards may not be suitable for all professions and in all cases.
- May also weaken the sense of ownership or control that stakeholders and professions currently have with profession specific accreditation standards.

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?**

No comment.

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?**

The new accreditation standards developed by the Council on Chiropractic Education Australasia are based on other contemporary and evidence-based Standards, particularly those adopted by the Australian Dental Council. They were also developed with the aim of maintaining equivalence with international standards. We understand that principles of inter-professional learning and practice are embedded in the standards. Nevertheless, the CAA would support further efforts to enhance interprofessional education and the promotion of interdisciplinary practice in accreditation standards.

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

No comment.
15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

No comment.

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?

Medicine, Pharmacy and some Psychology students are required to undertake a one or two-year internship following graduation. The CAA will leave it to relevant stakeholders to determine if this is still appropriate. There is no requirement for a period of supervised practice as a pre-condition of general registration in chiropractic. The CAA supports maintaining this position into the future. Chiropractic has historically been practiced in small, private practice based settings. This makes mandating a period of supervised practice much more difficult to implement in chiropractic than professions which have traditionally accessed structured graduate placements in the public healthcare system. We note however that each chiropractic program in Australia has its own supervised clinic where students undertake extensive clinical education prior to graduating.

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

We agree with the comment in the Discussion paper that accredited education programs should produce graduates with the required knowledge, clinical skills and attributes to safely practice as a health practitioner and who has an appropriate foundation for lifelong learning. We also agree “there is a lack of definition of what ‘work ready’ means”.

The CAA would support any approach to training that addresses identified gaps in work readiness (primarily how graduates function as a health professional within a system) and enhances mentoring and support for students in the early phases of employment to better prepare graduates to operate safely, effectively and with greater confidence. This last point is particularly important for smaller professions such as chiropractic that practice predominantly in small, private practice based settings. In these professions, access to appropriate mentoring/guidance as well as continuing education which aims to assist new graduates to develop their skills and to acclimatise to the particularities of a workplace is more difficult than in professions which traditionally access structured graduate placements in the public healthcare system.

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

Insofar as chiropractic is concerned, we believe current accreditation processes do negate the need for further national assessment before gaining general registration. A national assessment process would also add significant costs (time and financial) for students.
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?

Yes, because National Boards work closely with their accreditation authorities to effectively implement the National Registration and Accreditation Scheme. Key accreditation functions undertaken by most accreditation authorities include:

- develop accreditation standards and recommend them to the relevant National Board for approval
- accredit and monitor education providers and programs of study to ensure that graduates are provided with the knowledge, skills and professional attributes to safely practice the profession in Australia.
- provide advice to National Boards about issues relating to their accreditation functions
- assess overseas qualified practitioners.

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?

No comment.

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

In question five we state we would support a broader range of stakeholders to draw from when recruiting or selecting assessment team candidates, including consumers. Enhancing community representation in key accreditation decisions would also be supported by CAA.

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 Council on Chiropractic Education Australasia Limited is a company limited by guarantee which means Board members have very specific legal and ethical obligations. All representatives of the CCEA are expected to abide by Section 22 of the Council’s Constitution and Rules dealing with ‘disclosure of interests’. This is further elaborated on in the CCEA Conflict of Interest Policy. We believe these measures are sufficient to manage conflict of interest issues that may arise.

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?

No comment.
24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

No comment.

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.

No comment.

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

No comment.

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?

No comment.

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

No comment.

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?

No comment.

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?

No comment.

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

No comment.

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?

No comment.

33. Is there is 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?

No comment.

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

No comment.

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?

No comment.

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

No comment.

37. If an external grievance appeal process is to be considered:
   • Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
   • Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

No comment.