ATTACHMENT 1

Victorian Department of Health and Human Services (DHHS) submission to the *Independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions.*

**IMPROVING EFFICIENCY**

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

DHHS supports greater consistency and commonality in the development and application of accreditation standards.

The outsourcing of the development of accreditation standards to multiple separately constituted accreditation authorities has led to inconsistencies in language, style and processes for producing the standards, both within and across the professions.

There is considerable scope for improvement. This would be expected to:

- Reduce duplication, red tape and cost for education providers, thereby increasing efficiency, improving timeliness and responsiveness of the accreditation functions;
- Facilitate the accreditation of training programs that straddle traditional professional disciplines and scopes of practice;
- Generate essential data about the performance of the accreditation functions that can be used to facilitate continuous system improvement;
- Enable more strategic use of accreditation as a tool to improve the responsiveness of education and training systems to the strategic priorities of governments, such as family violence reforms, implementation of the National Disability Insurance Scheme, Closing the Gap and mental health initiatives;
- Streamline linkages and interfaces with other systems of quality assurance for training of the workforce, including with TEQSA and ASQA.

There are three National Boards (covering seven occupations) that deliver their accreditation functions via internally constituted committees supported by AHPRA. This model demonstrates that with a common governance, it is possible to deliver consistency in the development, framing and application of accreditation standards, across professions that are quite different in their scopes of practice and treatment modalities. The chief barrier to this occurring for the remaining 11 professions is the fragmented governance arrangements.

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?

DHHS supports better integration of the NRAS and TEQSA/ASQA accreditation standards and processes.

There is a need to clarify the interface between the TEQSA/ASQA and NRAS accreditation systems, including the respective objectives, roles and functions, standards and processes, so as to facilitate greater integration of the respective accreditation processes. The fact that this has not happened though the scheme is in its seventh year is a symptom of a broader
concern with the fragmented governance arrangements for delivery of the accreditation functions.

Work is required to identify areas of commonality, overlap and duplication, to guide reforms to achieve, at a minimum, more rational and efficient division of labour, and reduced costs for education providers.

Ideally, the TEQSA/ASQA accreditation should cover off matters of governance of education providers, facilities etc, and the NRAS accreditation should focus on those competencies required to meet contemporary requirements for practice in each profession as well as the need for innovation and inter-professional approaches.

At a minimum, there should be coordination of the timing of the various accreditation processes, to allow education providers that deliver programs across two or more professions to adequately plan and resource their responses.

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

DHHS supports a shift to more open-ended and risk-managed accreditation cycles, as long as this is evidence informed and supported by appropriate monitoring of the performance of education providers.

There is considerable scope for using risk assessment to design more nuanced accreditation processes including changes to accreditation cycles. In theory, the benefits should include decreased duplication, increased efficiency and decreased cost, for both accrediting bodies and education providers.

Such a shift relies on much better data about the operation of the accreditation system than is currently available, and far stronger monitoring of the performance of education providers. Sometimes a shift to a risk-based approach has been used as a justification for reducing resources, leaving providers to self-regulate without sufficient oversight. Public confidence in the quality of graduates relies on a robust accreditation system.

The current fragmented accreditation system does not provide the capability to generate with sufficient timeliness the data needed to inform policy decisions of this nature. Without governance reform, the potential for evidence informed design and delivery of the accreditation functions (for example, with respect to the length of accreditation cycles) is unlikely to be realised.

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?

DHHS supports evidence informed changes to accreditation processes, to increase efficiency, consistency and cross-profession collaboration.

It is essential that such changes are informed by evidence about what works, and what does not, drawn from the accreditation experience of all 14 regulated health professions, and other accreditation systems both nationally and internationally.
However, the current fragmented accreditation system does not provide the capability to generate with sufficient timeliness the data needed to inform policy decisions of this nature.

5. **Should the assessment teams include a broader range of stakeholders, such as consumers?**

DHHS supports the inclusion on assessment teams of persons who are not health practitioners, including consumers, to ensure a diversity of relevant skills and experience.

There is lack of clarity about the concept of a ‘community member’ within the National Scheme, and what skills and attributes community members should have in order to carry out the various statutory roles. Some consider community members should be health service consumers with a background in consumer advocacy, and with strong links with consumer representative groups and no alliances or links, past or present, with the regulated health professions. Others see community members simply as persons who are not from the regulated profession and who bring an independence of thought and useful skills and knowledge to their role, such as in governance, the law, finances, or education and training.

Securing and retaining members with the necessary technical expertise who are also free from conflict of interest is a continuing challenge for accreditation entities, particularly for the smaller professions.

The more members there are on an assessment team, the more costly the process. Assessment teams should comprise a mix of members, some from the profession regulated, some not. Members should bring a diversity of views and expertise to the team. In considering whether a ‘consumer’ member should be appointed to an assessment team, it should also be noted that there is a range of other potential vehicles for securing the input of consumers and consumer advocates, such as reference groups, focus groups and surveys.

The critical non-practitioner input needed on an assessment team is that of the educationalist – a person who is a specialist in the theory of education, and has knowledge and skills in the delivery of education generally, in the tertiary or vocational education system as appropriate. Also of benefit would be members who bring expertise in quality assurance from other industries and occupations.

A multi-profession accreditation entity would be better equipped to recruit, train and support assessment team members, and share critical non-profession specific expertise across teams.

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?**

DHHS supports greater transparency in the setting of fees and levies for funding accreditation functions.

There is little transparency in the current accreditation system with respect to costs. This includes how costs are apportioned between registration boards, accreditation entities and education providers, and on what basis funding decisions are being made.
The critical point is that there should be consistency where possible across professions, and a governance system that generates data to inform decision-making about financing. Under such a system, it should then be possible to identify where greater equity and efficiencies can be achieved.

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?**

DHHS considers that greater transparency in the setting of accreditation and assessment fees, including the rationale for fees set above the cost recovery level, would support debate on this question.

**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?**

DHHS supports the establishment of a national multi-profession accreditation policy and strategy capability that can provide evidence informed advice concerning the effectiveness of outcome-based and other approaches to standard setting.

A preliminary view is that expressing accreditation standards only in outcome-based terms may present risks, particularly in the short term. In moving towards outcome-based standards, it will be vital that education providers have quality systems in place to ensure they understand and are accountable for the contribution of inputs and processes to outcomes, and that they are able to report appropriately.

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

DHHS recommends an evidence informed approach is used to identify the outcome-based standards to be implemented, and how assessment procedures may then be changed to determine whether and to what extent the outcomes are being achieved.

It is important that outcomes are expressed in terms of learner outcomes and how well graduates are meeting the expectations of employers, funders and other stakeholders, and in particular the needs of the future consumer, service system and workforce. Assessment against these criteria will be very different to assessment of inputs and processes.

Assessment procedures will need to provide assurance that education providers have quality systems in place. For example, educational rigour as well as learner support, safety and experiences are key to development of the future workforce. Though it is possible to express such elements in outcome terms, the likelihood and consequences of lapses in inputs and processes may be high (for students in particular) and therefore need to be considered on the basis of potential risk.
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?

DHHS supports a common approach to the development of professional competency frameworks and to the inclusion of consumers and others in the process.

This common approach should apply across all 14 regulated health professions, with a common suite of standards for the scheme as a whole. There should also be scope for profession specific standards, and processes within such a system. TEQSA provides a precedent.

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

DHHS supports the development of accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements.

The current fragmented governance arrangements present a risk in developing and adopting integrated approaches to the delivery of accreditation functions. There will need to be provision for the profession specific components and access to sufficient expertise in designing these.

Consideration of the balance between common elements and profession specific requirements will be important in ensuring that the future workforce is fit for purpose for both universal and specialist service delivery. This needs to consider the balance between generalist and specialist workforces, and any changes to policy and practice that may shift workforce demands in the future.

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?

DHHS supports greater transparency in the delivery of accreditation functions. This should include public access to web-based information about the results of accreditation assessments and supporting evidence, including those components managed by TEQSA/ASQA. There should be a coordinated assessment process for those education providers that provide programs for multiple professions.

The current complex and fragmented arrangements make it very difficult for governments to effectively implement in a timely manner strategic and system-wide responses to challenges such as family violence and Indigenous disadvantage. A single national agency would provide a focal point for driving such reforms.

There also needs to be an evaluation and evidence capability to ascertain to what degree graduates have the knowledge, skills and attributes required for the current and future system. This would allow evidence informed decisions about improving the accreditation system to improve health outcomes.
13. How best could inter-professional education and the promotion of interdisciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

DHHS supports a greater focus in qualifying programs on inter-professional education and the promotion of inter-disciplinary practice. The accreditation standards and processes are key tools for delivering the refocusing of training needed to achieve this.

A well-funded multi-profession evidence capability could focus on what are successful models to better prepare students for inter-disciplinary practice.

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

DHHS supports better use of the accreditation standards and processes to embed healthcare priorities within curricula and clinical experiences.

Healthcare priorities should be expressed as outcomes, with education providers accountable for ensuring curricula and clinical experiences are in place to assist in achieving these priorities. The system needs to retain the flexibility of different educational approaches while ensuring accountability of education providers, in collaboration with other stakeholders, for demonstrating that the required healthcare priorities are being addressed.

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

DHHS supports the timely incorporation of contemporary education practices into curricula and clinical training.

Curricula must reflect technological change that is revolutionising professional practice. However, use of technology-based education and other contemporary education practices must be based on evidence of effectiveness.

The costs of testing simulation-based education may be beyond the resources of many professions, particularly the smaller professions. A multi-profession governance may enable the costs of research and testing to be shared amongst all professions that have the potential to benefit.

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?

DHHS acknowledges that the need for supervised practice as a pre-condition for registration is likely to vary by profession, depending on factors such as:

- the risks associated with clinical practice
- the types of interventions involved, and
- the extent of clinical experience built into the qualifying program.

A multi-profession policy and evidence capability will assist in determining whether the resources required to deliver supervised practice arrangements (for those professions that have these arrangements) are yielding a net public benefit (that is, the benefits outweigh the costs and there is no other less costly method of achieving those benefits).
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

DHHS acknowledges that these are fundamental questions that require an evidence informed approach. There is no single answer, and what constitutes work readiness will change over time.

An effective multi-profession policy and evidence capability would equip educators and regulators with the tools to ensure the education and training system is able to graduate practitioners who are ready for initial practice, and are competent, responsive and adaptive to the health needs of the community.

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?

DHHS acknowledges that this is a fundamental question that requires an evidence informed approach and consideration of the differences between professions.

To take medicine as an example, there are already accreditation processes in place for both professional-entry qualifications and prevocational training. There are arguments regarding to what degree clinical placements can develop the capability and attributes of medical students and assist them to meet the requirements of general registration. As student outcomes are largely assessed by the education provider, while intern outcomes are largely assessed by an employer, the current system, in medicine at least, provides a level of assurance of 'work readiness' of graduates. It also allows innovation and variation in educational provision while ensuring a more standardised transition to practice assessment to ensure the efficacy of registration to practice.

Changes to the current registration system would not be supported without a robust evidence base, along with changes to educational provision and accreditation processes to assure safe, quality practice.

PRODUCING THE FUTURE 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?

DHHS considers the accreditation of education and training programs as an integral component of the registration function – a means of determining whether applicants for registration are suitably qualified, by assuring the training they undertake rather than the alternative mechanism of requiring successful completion of a board run/commissioned examination.

It is for reasons of history and in response to our federal system of government that the delivery of accreditation functions was established and delivered under separate governance. From the 1980s on, state based boards realised that accreditation functions were beyond the resources of individual boards to carry out effectively. So they joined forces
to establish a governance structure to enable them to deliver these important functions at a national level.

National Board members are appointed because they are highly qualified and leaders in their respective areas of expertise. While practitioner members bring a wealth of experience, it is not possible for National Boards to have at the table all the skills, knowledge and expertise needed to carry out the accreditation functions.

However, due to the connection between the accreditation and registration functions, National Boards should have an ongoing role in the accreditation system, to ensure accreditation standards meet their responsibilities in relation to registering students and practitioners. For example, if there is to be a separately constituted multi-profession accreditation agency, it would be recommended that National Boards nominate members to sit on the board of the agency. National Boards should also be consulted on any proposed new or revised accreditation standards.

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?

The future health workforce will be required to work across professions, within integrated services, in new and flexible roles, delivering person-centred care. The current profession-led accreditation system, with 14 accreditation councils or committees, maintains a profession focus which presents challenges in developing the future workforce.

DHHS recognises that the accreditation system operates within a broader context of educational and service quality. As well as considering specific reforms within the National Registration and Accreditation Scheme, DHHS recommends the Review considers the place of accreditation entities within the ‘federation’ of agencies with an involvement or interest in educational quality and appropriateness. This includes an examination of the roles and expectations of all key beneficiaries of accreditation systems, including funders, other regulators, employers, peak bodies, professional associations, workers, educators and consumers.

Independence would be of benefit in establishment of a multi-profession policy and strategy function of the agency. This would support an outcomes-based approach to accreditation of health education and training by providing a link between accreditation levers and results and the achievement of priority health system and reform outcomes. The proposed national agency would identify where changes are needed to accreditation standards and program assessment/approval processes to drive workforce reform and improve alignment of workforce development, education and training with evolving needs and expectations of consumers, workers and services.

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

DHHS considers that any entity responsible for making statutory decisions should be constituted in a way that ensures a diverse range of views and expertise is brought to the table, not just those from the profession regulated. This means there should be a reasonable
proportion of 'community' or 'lay' members appointed, with transparency about the method of appointment.

There is opportunity for more transparency about the membership of some accreditation councils and the appointments process. For instance, the Australian Physiotherapy Council has two member companies, and the website directs the reader to the websites of these two companies. Information about the membership of one of the companies (the Council of Physiotherapy Deans Australian & New Zealand) could not be readily accessed because it requires a login. It is not clear from the website whether any of the members of the Australian Psychology Accreditation Council are community members since no information could be located on the website about the qualifications of Board members.

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?

DHHS concurs with the OECD that the involvement of stakeholders in strategic decision-making is best secured via stakeholder engagement mechanisms such as advisory and consultative committees, rather than making stakeholders members of the regulator’s governing body.

While sourcing suitable profession specific experts without conflicts of interest is a challenge under any governance model, a multi-profession governance arrangement would be expected to:

- focus members on the skills and attributes they bring to the role, rather than their profession-specific interests
- systematise and strengthen the arrangements for recruiting, training, and supporting those who carry out accreditation assessments, and
- free some professional members from their governance responsibilities so that they are more available for accreditation panels and other roles.

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?

DHHS believes there should be more transparency and accountability of entities that are carrying out regulatory functions on behalf of National Boards to ensure appropriate delivery of public interest functions.

Accreditation activities are part of councils’ obligations as legally constituted companies, and in some cases may also be considered as part of their commercial activities. This means a separation of functions may not be feasible.

There would be benefits in the Review examining and learning from the governance arrangements and accountability measures of other agencies that have a public interest function and outsource certain functions to other entities.
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?

DHHS is of the view that the standard clauses in funding agreements between AHPRA and the accreditation councils are inadequate as a tool for delivering strategic reform of the education and training sector. These governance arrangements are ill-equipped to drive the reforms needed.

Reliance on the Health Professions Accreditation Councils’ Forum as the key mechanism for coordination and to drive strategic multi-profession reform will not deliver the pace of reform that is required to meet the future needs of consumers and health services.

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.

To enable delivery of workforce and service system reforms and the achievement of national health and wellbeing priorities, DHHS supports a change to the governance of the accreditation system. Rather than maintaining a direct link between separately constituted accreditation entities and the profession-specific National Boards, the department would support a single national multi-profession agency to govern some or all accreditation functions, including policy direction, standard setting, evaluation and guidance functions.

Rather than establish a new entity, our preference is to amend the National Law to expand the remit of an existing entity. The department would support the Australian Health Practitioner Regulation Agency (AHPRA) Agency Management Committee having this role. This would support the agency linkages outlined in this submission.

There are ample examples of successful multi-profession delivery of accreditation functions, notably TEQSA, the United Kingdom’s Health and Care Professions Council, and AHPRA (for three professions). Consolidation of the functions under a single multi-profession statutory regulator would be expected to free up resources that could be used to build policy and evidence capability and improve the effectiveness of the functions.

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

DHHS notes that the United Kingdom Health and Care Professions Council provides a suitable model for achieving a cross-profession approach to accreditation that fosters cross-professional competencies, while at the same time securing the necessary profession specific input. Similarly, the committee arrangements established by three National Boards and supported by AHPRA, and the NRAS itself, demonstrate the benefits and capabilities that a multi-profession governance model can deliver.
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?

DHHS considers the establishment of a multi-profession governance structure with a strong policy, strategy and evidence capability would enable significant improvement of performance measurement, reporting and monitoring and would increase transparency and accountability in the delivery of these functions.

A common reporting framework would enable comparisons to be made across professions, as is now available for the registration function. It is not possible to achieve a whole of scheme perspective under the current fragmented arrangements, or to progress strategic whole of system reform with any timeliness.

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

DHHS considers the approval of accreditation standards by the Ministerial Council should be aligned with the process for approval of registration standards, given the importance of education and training to the development of the future workforce. There needs to be ample opportunity for jurisdictions to have input during the development stage, with sufficient mechanisms to resolve conflicts or concerns about the content or application of standards as they arise.

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?

As a matter of principle, Ministerial Council powers should be aligned where relevant with all National Law objectives. DHHS is open to options for amending the grounds for the Ministerial Council to issue directions under section 11(3)(d), to broaden the scope of the power to capture directions issued in the public interest, such as to address national health priorities and challenges.

It should be noted that it is very unusual for the Ministerial Council to issue a direction, as most issues are resolved through negotiation between the NRAS agencies and individual jurisdictions, or via the national committee structures and processes.

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?
DHHS considers there is a need to strengthen the mechanisms through which jurisdictions jointly identify reform priorities concerning the accreditiation functions and negotiate and agree performance targets and measures with the agencies of NRAS. The Ministerial Statement of Expectations process that has been implemented in Victoria is a key tool for negotiating priorities for reform and setting performance measures with statutory regulators. Ideally such a process should be occurring on a three yearly cycle, with annual review.

Further information about the Victorian Ministerial Statement of Expectations process can be provided on request.

With respect to the engagement with key stakeholders such as educational institutions, professional bodies, consumers and relevant experts, this will continue to be a challenge without governance reform. The NRAS already provides an effective model for engagement with stakeholders in relation to registration functions, where AHPRA has established reference groups with all the major stakeholder groups, and time limited committees and focus groups are convened from time to time as needed. These structures are very useful to jurisdictions, since they can ‘piggy back’ on the existing arrangements when national consultations are required. The time savings are significant. Similar arrangements are required in relation to the accreditation functions under the National Scheme.

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?

DHHS considers the multi-layered arrangements do not provide sufficient scrutiny of these functions – in particular the outcomes achieved and opportunity costs. Further research and evaluation is needed on the costs and benefits of the current approach, focusing on both training providers and health services.

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?

DHHS notes that this already occurs for some professions and would support further investigation of alignment opportunities.

33. Is there a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

DHHS notes that assessment of overseas trained practitioners may include consideration of both the equivalence of a qualification to an Australian qualification and the competency of the individual practitioner.

DHHS would support further investigation of whether assessment of overseas trained practitioners could be carried out in house by a responsible National Board, with administrative support from AHPRA.

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?
DHHS considers that while there will be commonalities, the number of pathways available for assessment of overseas trained practitioners may differ depending on the size of the profession and other factors. For instance, the resources required to operate a ‘competent authority’ pathway (such as that which operates in medicine) may not be justified for a small profession with low numbers of applications.

Governance reform would open up options for greater consistency in the delivery of assessment pathways, and for sharing of resources.

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?

DHHS considers that supervised practice is an important tool for ensuring that overseas trained practitioners have sufficient orientation to and understanding of the Australian context of practice. There are other tools used by National Boards.

Governance reform may enable different approaches to be trialled, to facilitate evidence informed policy on such matters.

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

DHHS considers that the AHPRA/HPACF guidance document does not provide a sufficiently transparent and fair mechanism for dealing with complaints and grievances from education providers, health services and from overseas trained practitioners who sit examinations. There is also little transparency and accountability with respect to the charges levied by accreditation authorities, or for appealing examination test results.

Siting the accreditation functions with a multi-profession accreditation agency would enable formalisation of the grievance procedures for both education providers and examination candidates.

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?

DHHS supports an examination of a potential statutory role of the National Health Practitioner Ombudsman to deal with appeals arising from the decisions of the accreditation authorities, noting that these entities are exercising accreditation functions under contract.

If the accreditation functions were to be sited with a multi-profession accreditation agency, then it may also be appropriate for appeals concerning the administrative decisions of such an entity to lie with the National Health Practitioner Ombudsman, including matters such as the fees charged.