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

Division of Tropical Health and Medicine

James Cook University

May 2017
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Executive Summary

James Cook University’s (JCU) Division of Tropical Health and Medicine (DTHM) welcomes the opportunity to make a submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme (NRAS) for Health Professionals.

As well as offering responses to selected review questions, the submission provides general comments and recommendations against the three main themes of the review: efficiency, relevance and responsiveness, and producing the future health workforce.

We see significant scope for efficiency improvements in higher education health course accreditation. In particular, we emphasise the importance of identifying opportunities to streamline processes to minimise duplication of duties and requirements, many of which are currently onerous and costly. Our focus in this area is on strategies to reduce duplication and streamline accreditation processes, such as identifying common sets of evidence, effecting better coordination with TEQSA, minimising disruption of accreditation on core university business by coordinating accreditation activity across disciplines, combining ‘back office’ costs and reducing the size of accreditation teams.

We suggest that relevance and responsiveness of accreditation systems can be improved by ensuring appropriate and consistent scope of accreditation activity, avoiding drawn-out accreditation processes and coordinating site visits to ensure minimal disruption to core business and to minimise overlap with other accreditation visits. We also highlight the value of inter-professional clinical placements and the need for supervision requirements to facilitate inter-professional experiences, which is necessary to enable placements within many rural and remote clinical settings.

Producing the future health workforce requires responsiveness to national priorities, which include responding to the globalisation of the health sector. This agenda will require establishment of flexible accreditation and registration systems that can respond to new health system developments, including development of innovative, flexible and standardised approaches to accreditation of overseas programs and registration of overseas health professionals, to enable health workforce mobility across nations. We also highlight the need for accreditation systems to foster innovation within accredited courses, and to foster the critical thinking skills that are increasingly necessary in graduates in a globalised marketplace.

Recommendations

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1. Introduction

James Cook University's (JCU) Division of Tropical Health and Medicine (DTHM) welcomes the opportunity to make a submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme (NRAS) for Health Professionals.

DTHM has long had a unique commitment to addressing health workforce shortages in regional, rural, remote and tropical areas through the provision of a professional, work-ready health workforce. The success of our approach has seen growing numbers of JCU graduates choosing to live and work in areas of health workforce need.

DTHM runs 100 academic programs at undergraduate and post-graduate levels across three main teaching sites and several smaller sites. The Division’s accreditation activity in numbers is as follows:

- 11 Academic Groups within DTHM offer accredited programs;
- DTHM offers 25 accredited courses (including Bachelors, Honours, Graduate Certificate, Graduate Diploma, Masters and Doctorate programs);
- 19 of those 25 courses have mandatory accreditation;
- 6 of the 25 courses have voluntary accreditation (but graduate students cannot gain professional association membership without completing an accredited program); and
- 12 different professional accrediting bodies are responsible for accreditation of DTHM programs.

Some form of preparation, planning, monitoring and production of accreditation-related materials occurs every day in DTHM, with each Academic Group managing its own accreditation process. Oversight and support is provided by the Division’s Director, Academic Quality and Strategy, and a Curriculum Management Office, which provides support in preparing for, progressing and polishing accreditation-related materials. Accreditation is a standing item on relevant committee agendas, and processes are guided by the University’s Accreditation (Professional) of Courses and/or Disciplines policy. The University’s Quality, Planning and Analytics section maintains a register of accreditation activity.

We emphasise the importance of accreditation standards in enabling universities to enforce requirements and expectations of students. The accreditation process and associated professional requirements also provide a point of leverage in respect of ensuring adequate resourcing of programs. Accreditation also allows for identification of areas for continual quality improvement that may not be readily identified by the JCU academic and professional staff. However, accreditation processes can be improved, and DTHM’s suggestions for development and refinement of accreditation systems for health professionals are outlined in this submission.

As well as offering responses to selected review questions, the submission provides general comments and recommendations against the three main themes of the review: efficiency, relevance and responsiveness, and producing the future health workforce.
2. Improving efficiency

2.1 General comments:

We see significant scope for efficiency improvements in higher education health course accreditation. In particular, we emphasise the importance of identifying opportunities to streamline processes to minimise duplication of duties and requirements, many of which are currently onerous and costly. We recommend that the following actions are taken to enhance efficiency:

Reduce duplication and streamline accreditation processes

Common sets of evidence

Each of the 12 professional accrediting bodies to which JCU reports has different fee structures, different accreditation cycles of between three and 10 years, and different requirements. Many accrediting bodies also have an annual monitoring/reporting requirement. Some standards (e.g. information about the structure of the organisation, information resources infrastructure, policies on learning and teaching, student selection, admission and progression, student support structures, and issues relating to professional practice) are required to be met by all accrediting bodies, yet each of the accreditation bodies seek this information separately.

Whilst there are benefits associated with considering the different disciplines separately and distinctly, there is scope to reduce duplication in requests for common sets of evidence.

Recommendation 1: To reduce duplication, we recommend that common sets of evidence required by accreditation bodies are identified across the disciplines. Universities should then only be required to submit common sets of evidence once, directly to a single coordinating body (e.g. AHPRA). One approach could be to develop a common template for use by universities to show that a university-level standard has been met, across all accreditation bodies.

Coordination with TEQSA

There is some overlap in the data required by TEQSA and that required by accreditation bodies. Developing data sharing mechanisms between TEQSA and the accreditation bodies may therefore lead to shared efficiencies and cost savings. Efficiencies could also be gained through closer collaboration between accrediting bodies and TEQSA around key issues that have been independently identified as impacting on institutional capacity to deliver on accreditation requirements.

Recommendation 2: We recommend that data sharing mechanisms between accreditation bodies and TEQSA are investigated, and that a coordinating body (e.g. AHPRA) liaise with TEQSA once per accreditation cycle to identify issues impacting on institutional capacity that have been already identified via independent assessment. In doing so, we recommend that a clear delineation between the role of TEQSA and that of accreditation bodies is maintained.

Coordination of accreditation activity across disciplines

Each accreditation process involves hundreds of hours of work of between 10 and 30 staff members, resulting in the production of a finely-detailed report, collation of hundreds (sometimes thousands) of pages of supporting material, and preparation and management of the related accreditation site visits. Site visits typically involve a four to eight-member accreditation review team, senior University representatives from a number of different Divisions and Directorates, clinicians, external professional representatives and students and might take place on each of JCU’s campuses and external sites.
The demands of this accreditation activity in DTHM vary significantly from year to year, which creates challenges for workload planning and budgeting. In 2015, for example, almost half of the Division’s externally-accredited courses were due for renewal: seven academic groups were audited and reviewed by their external accrediting bodies in a single year. In comparison, in 2016, four Academic Groups worked on accreditation-related reviews or visits. Accreditation activity and demands during teaching semesters can be particularly challenging for staff in balancing the extra workload with teaching responsibilities.

**Recommendation 3:** To minimise variation and assist planning, we recommend that initiatives are developed to minimise disruption of accreditation on core business, such as establishing a requirement for accrediting bodies to coordinate their activity with other accrediting bodies active in the same year. It may also be possible for accreditation bodies to provide universities with an option to respond in a timeframe that does not interfere with discipline workloads for teaching.

**Ensure greater consistency in definitions and practices**

Similarities are evident in each profession’s reporting standards (e.g. standards relating to financial operations, student support and facilities) but definitions and practices differ greatly.

Some commonly-used terms, such as ‘retention’, are ascribed different meanings by professional accreditation bodies, higher education accreditation bodies and the universities themselves. Variations are also evident in who is counted as an ‘Academic’ e.g. adjuncts, placement supervisors, contractors. These distinctions are important when working out staff/student ratios. In addition, the way a term is defined guides the way supporting data is collected. As such, there is not always a good match between the data produced by a university and the data sought by accrediting bodies.

**Recommendation 4:** We recommend that systems are developed to ensure appropriate and consistent definitions of key words and practices relating to information sought by accreditation bodies, across all professions.

**Reduce and streamline accreditation costs**

*Accreditation costs*

The cost of accreditation is high, in terms of both fees levied by the professional accrediting bodies and costs related to producing the accreditation report and managing site visits.

A very significant investment of time and effort goes into meeting DTHM’s accreditation requirements. Generally, Heads of Academic Groups report that the costs associated with preparing for accreditation and site visits is around $100,000 to $200,000, meaning five-yearly costs to this Division of the University are in excess of $1.5 million (accreditation is generally a five-yearly process) or $300,000+ a year. Quantifying the exact cost, however, is difficult because complicated accreditation processes (as illustrated below in Case Study 1) can be three-times the average. Variables include fees, number of people on the accreditation panel, number of teaching sites visited, and level of detail required for reporting, which is not always known/transparent or communicated to the University up-front.

Cost-reduction approaches might include combining ‘back office’ functions (outlined below) and reducing duplication (outlined above).
Case Study 1

Costs and workload associated with a single course accreditation report and site visit: July 2016

Estimated accreditation preparation-related costs = $600,000

- Travelling expenses for the eight-person accreditation review team; two members from the United Kingdom, two from New Zealand and four from various cities of Australia
- Accommodation, transport, catering and activities in Cairns, Malanda and Townsville for the review team for eight nights and seven days
- Secondment of professional and technical staff to work on site visit and report, including the appointment of a project manager at 0.8 for a six-month period
- Accreditation fees
- Nine (including Senior) academic staff and six administrative, professional and technical staff contributed significant and on-going hours and support to the accreditation process (and opportunity costs)

Summary of accreditation activity

- Production of a finely-detailed 70-page report covering 12 standards. Reporting for each standard involved input from between two and four academics and managers
- Compilation of several thousand pages of appendices, supporting and supplementary information
- Mock accreditation sessions held to support in-house staff preparedness
- Organisation of the week-long site visit which involving scheduling and organising daily meetings, luncheons, field trips to outside facilities, and coordination of students from all year levels, academic group staff, external student supervisors and University senior executives who needed to be on-hand to answer questions from the accreditation team.

‘Back office’ costs

There may be efficiency gains in combining/coordinating backroom administrative functions across the multiple accreditation boards. As well as reducing costs, this may also improve response times. This function could be undertaken by a single coordinating body (e.g. AHPRA) which could coordinate common sets of evidence required by all accreditation bodies, accreditation visit coordination, accreditation appeals and other back office functions. A proportion of professional registration fees could be directed to support this purpose.

Size and composition of accreditation teams/panels

Accreditation panels are often unnecessarily large, increasing the costs of accreditation on higher education providers. We recommend that accreditation boards seek to reduce the size of accreditation panels to the minimum necessary to undertake site visits and assessment. This will also assist universities to plan travel requirements and estimate costs in advance of visits. Some consistency in remuneration of assessment teams may assist in reducing costs, but for some disciplines this may actually increase costs.

A number of accrediting authorities rely on bringing together representatives from industry and academia to build their accreditation teams. This model presents challenges in circumstances where accreditors come from competing universities, where there is potential for bias or conflicts of interest. In addition, revolving team members limit the opportunity for training programs to build the knowledge and skills required of accreditation teams within the rapidly evolving health system.
To address this, accrediting authorities could employ permanent accreditation teams, bringing in external expertise as required, similar to the model used by TEQSA. These permanent teams could then be offered training to improve consistency, and to ensure that team members are apprised of contemporary learning and teaching approaches. Note, however, that this approach would remove the benefit of cross-fertilisation of ideas that comes from having diverse accreditation teams.

**Recommendation 5:** We recommend that cost-reduction strategies are investigated to reduce both the direct and indirect costs of accreditation on universities, including combining/coordinating backroom administrative functions across the multiple accreditation boards, and reducing the size of accreditation teams.

**Recommendation 6:** We recommend that permanent accreditation teams are established, bringing in external discipline/professional expertise as required, with training offered to improve consistency and ensure that team members are apprised of contemporary learning and teaching approaches.

### 2.2 Responses to questions:

**Accreditation standards**

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

Overall, we see scope for greater consistency and commonality in the development and application of accreditation standards across the disciplines, but this should not entail disbanding the discipline-specific accreditation bodies. A key action should be to consider an approach to coordinating collection and assessment of common sets of evidence across disciplines, to be collected by a single coordinating body (e.g. AHPRA).

**Benefits:**

- Common sets of evidence are identified across disciplines, reducing time and costs associated with duplicative data collection and assessment;
- Standardisation of accreditation processes, enabling workload planning and enhancing efficiencies.

**Risks:**

- Possible loss of individual nuances pertaining to different professions, if ‘greater consistency and commonality’ is implemented too broadly;
- Fewer accreditation staff who have direct academic and clinical experience within each discipline (if accreditation bodies/functions are amalgamated).

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?

AHPRA, as a coordinating body, should liaise with TEQSA once per accreditation cycle to identify issues impacting on institutional capacity that have been already identified via independent assessment.

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

Overall we highlight the benefits associated with adopting more open-ended and risk-managed accreditation cycles but emphasise the importance of adequately defining and assessing ‘risk’.
**Benefits:**

- Organisations, which are determined to be ‘low risk’, have fewer accreditation assessment requirements and therefore fewer accreditation-related costs and time commitments.
- The accreditation authority is better able to focus on the more ‘high risk’ organisations that currently either slip through the net or demand additional resourcing that low risk organisations end up subsidising.

**Risks**

- A ‘low risk’ status could change rapidly, challenging the feasibility of this model.
- Potential for loss of academic integrity and degree relevance, if assessment of risk is inadequate.
- Not having a defined period of accreditation could reduce the capacity of universities to assure students and potential students that they will be able to register and practice after graduation. Yearly assessments help to minimise this risk.

**Training and readiness of assessment panels**

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 inter-professional collaboration?**

Decreasing the size, increasing consistency and minimising real or perceived conflicts of interest of assessment teams should all be considered in relation to training and readiness of assessment panels. Overall, we recommend that accrediting authorities consider employing permanent accreditation teams, bringing in external discipline/professional expertise as required, similar to the model used by TEQSA. These permanent teams could then be offered training to improve consistency, and to ensure that team members are apprised of contemporary learning and teaching approaches.

Processes for selection and training of assessment teams could be shared to save accreditation bodies from creating the same processes and material. A dedicated office (e.g. within AHPRA) with specific functions shared across all accreditation bodies could determine specific standards and processes with regards to a range of common issues, including selection, training, composition and remuneration of assessment teams.

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

Overall, we recommend that consumers are not included on assessment teams.

Inclusion of a broader range of stakeholders may be useful and inclusion of consumers may offer 360 degree feedback as well as serve to communicate the importance of the scientifically-based professions to end users. However, including consumers would likely increases costs as there would need to be considerable training to enable these stakeholders to understand university processes as well as the full scope of practice that a discipline may require. Input from consumers is already obtained at other critical stages, including during the development of the accreditation standards.

Assessment teams should, however, include industry representatives, who are either actively working or recently retired from industry and academia and who understand both sides of the process.
Sources of accreditation authority income

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?

Suggested principles:

- A proportion of income from registrants can pay for accreditation functions;
- Calculation of the costs of accreditation should incorporate all functions of accreditation including the costs associated with site visits, review of documentation, report writing, administration processes, and systems for document storage;
- Fee-setting needs to be consistent across disciplines;
- The activities of accreditation authorities needs to be streamlined and costs rationalised;
- Governments need to adequately fund programs that lead to professional registration to reduce the burden on educational institutions.

7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

Overseas practitioners should pay a reasonable fee to ensure that they are a capable practitioners and that the public is assured of access to quality and safe health care. This amount should take account of the full costs of a robust accreditation system. Any cross-subsidisation should be cognisant of the need to avoid any perverse incentives to overcharge purely to increase revenue streams. The degree of cross-subsidisation possible may also vary depending on the numbers of overseas applicants.
3. Relevance and responsiveness

3.1 General comments:

We recommend that the following actions are taken to enhance relevance and responsiveness of accreditation processes:

**Ensure appropriate and consistent scope of accreditation activity**

Accrediting bodies sometimes seek information about issues that may be beyond their remit of assuring quality and completeness of education for that professional group. For example, a recent accreditation process at JCU looked deeply into the way the University managed depreciation of assets, which was not considered by the Academic Group to have any bearing on education standards and practices. In that same visit, suggestions were also made about overall University governance and business practice. Recommendations were also made about non-university facilities used by JCU for professional experience placement, where it was suggested these outside entities needed to change parts of their operations and build new infrastructure.

**Recommendation 7:** We recommend that that there is consistency in accreditation bodies’ understanding of the scope of their role and activity, and that the scope be limited to clear directives determined by the accreditation boards.

**Facilitate clinical placements in rural, remote and international settings**

Accreditation requirements often restrict DTHM’s capacity to administer clinical placements in strategic locations, including in areas relevant to students’ future practice where there is high health workforce need. Highly prescriptive requirements about the experience of clinical supervisors, types of settings and quality of facilities in some specific disciplines limit the University’s ability to offer students ‘accredited’ professional experience placements, particularly in rural, remote and international settings. The barriers relate to limited provision for inter-professional supervision, including strict ‘who, what, where’ guidelines.

**Inter-professional supervision**

More work is needed to facilitate inter-professional supervision of students undertaking clinical placements. Allowing greater flexibility for inter-professional supervision will open up new clinical placement opportunities in rural and remote settings as well as improve inter-professional practice generally.

Medicine provides an example of a multi-professional approach to clinical supervision for students on placement in range of practice settings (see Case Study 2). Physiotherapy also includes statements such as “Students are supervised by suitably qualified and registered physiotherapy and health practitioners during clinical education” within their standards, which allow for inter-professional education.

However, in some disciplines, there is limited to no provision for students to be supervised by a clinician from a different profession to their own, which fails to take account of the diversity of clinical practice environments and specialities and the predominance of team-based models in rural and remote practice settings. Clinical psychology, for example, requires that any placements external to the university and not supervised by an academic member of staff must be supervised by a field supervisor who is formally recognised by the university and who holds current registration as a psychologist with the relevant registration board. This type of restriction is a key rate limiting factor for clinical placements in rural and
remote locations, where there are fewer types of professionals compared with larger hospitals and health services.

**Recommendation 8:** We recommend that in order to facilitate inter-professional placement experiences and appropriate supervision standards, the development of a compulsory standard/guideline for universities across all professions is considered. This could be administered by a single coordination body (e.g. AHPRA) as part of the suite of ‘core’ functions undertaken by this body across all disciplines.

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### Case Study 2

**Medicine’s approach to enabling inter-professional clinical training in a range of practice settings**

The Australian Medical Council’s Standards for Assessment of Accreditation of Primary Medical Programs (2012) lists standards relating to clinical supervision. These standards emphasise the need for an effective system of clinical supervision, requirements for training, orientation and monitoring of performance of supervisors, and the need for clear definition of the responsibilities of practitioners who contribute to the delivery of medical education. The standards are not prescriptive about the types of health professionals that can supervise students. The standards also emphasise the need for the students to work with and learn from other health professionals including experience working in inter-professional teams.

JCU could not run a high quality program incorporating diversity of clinical exposure without access to supervisors from a wide range of disciplines and specialties. JCU’s medical students are supervised by many different clinicians in the following settings:

- **Rural placements** (every student does a minimum of 20 weeks across Years 2, 4, 6). On these placements, students are typically supervised by registered nurses, pharmacists, a variety of therapists, paramedics and other health professionals. In Mount Isa, students may do a week in the community with a variety of health workers, including Aboriginal Health Workers (AHWs). AHWs may also supervise students in many other settings including Aboriginal Community Controlled Health Centres. Indeed, some placements like Boulia (where students may spend 2 weeks in Years 2 or 4) have no resident doctors, so the majority of supervision is undertaken by other staff. Students may also do outreach with visiting allied health teams in the Gulf and in Cape York.

- **All students** do a 2-week health elective at the end of Year 1 and are encouraged to do this in a non-medical setting, i.e. many of them have their entire supervision for this period by non-doctors, including a variety of community organisations.

- **Within larger hospitals**, a significant proportion of supervision is also delivered by a range of staff including specialists such as renal nurses and renal dietitians, diabetic educators, Occupational Therapists who specialise in wound care, and nurse practitioners.

- **JCU’s clinical skills teaching** involves supervision by many different specialties – registered nurses, physician assistants, and doctors of different specialties.

**International placements**

DTHM students can elect to undertake placements in multiple overseas locations. In these locations, the facility requirements and supervision and assessment processes vary widely between the professions.

As part of its strategic agenda in health workforce innovation and development across the Asia Pacific region, DTHM is seeking to grow its international placement activity. More flexibility around who can supervise students would facilitate this growth, but this needs to be driven by the particular needs of the
profession. It may be possible to streamline and coordinate processes of identifying overseas locations for clinical placements which provide an appropriate learning experience for students.

**Recommendation 9:** We recommend that processes of identifying suitable overseas locations for clinical placements are streamlined and coordinated across the professions.

**Improve responsiveness**

*Drawn out accreditation processes*

Generally, site visits occur three to four months after submission of a self-evaluation report. The time from site visit to final approval will be another three to nine months. An efficient accreditation process, therefore, will take between six and 12 months. In some cases the lag time can be significant and problematic.

Good practice is evident in Occupational Therapy Australia (OT Australia), which manages national and international level accreditation from start to finish in under six months. OT Australia are not too prescriptive as long as the basic professional competencies are addressed, and as such the accreditation processes facilitate innovation and necessary changes in curricula. OT and several other associations have also moved to annual reporting which will reduce the burden of time associated with producing the self-study every five years.

Whilst the registered professions have made some headway in reducing delays, the non-registered professions sometimes rely on volunteers and part-time facilitators, which may contribute to the often substantial delays experienced in accreditation processes. Case Study 3 shows a recent experience of a drawn-out accreditation process at JCU involving a non-registered profession. There may be a role for a coordinating body (e.g. AHPRA) to assist in building the capacity of non-registered professions to develop robust, rigorous and sensible accreditation processes which will improve quality and benefit the sector overall.

**Recommendation 10:** We recommend investigating a role for a coordinating body (e.g. AHPRA) to assist in building the capacity of non-registered professions to develop robust, rigorous and sensible accreditation processes which will improve quality and benefit the sector overall.

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**Case Study 3 – drawn-out accreditation process at JCU**

- Self-evaluation reports for one of JCU’s accredited courses were submitted in September 2014, which was 21 months before the scheduled expiry of accreditation July 31, 2016.
- Five months later, requests were made for further information and JCU fulfilled these requests within a month.
- Six months after the initial submission, in March 2015, the University was advised the site visit would be held on 28 September – 1 October 2015, 12 months after submission of the initial self-evaluation report.
- In the eight months following the site visit, three accreditation body reports and three JCU responses were passed back and forth until the final one by JCU in July 2016.
- Course accreditation expired on July 31, 2016 and JCU was waiting for a response for 1.5 months. All marketing and course material has had to be amended as follows: ‘*re-accreditation for this course is under consideration.*’
- The outcome letter was received on 19 September 2016.
Negotiation in timing of site visits
There is often no negotiation on the timing of the site visits. For example, the focal site visit and the full accreditation visit for the Veterinary Sciences occurred in the first weeks of Semester One and Semester Two—the busiest times of the academic year.

Recommendation 11: We recommend that a coordinating body (e.g. AHPRA) have as one of its functions the capacity to coordinate site visits to ensure minimal disruption to core business and minimal overlap with other accreditation visits.

Improve clarity of process
A lack of clarity is sometimes experienced by DTHM regarding process requirements. For example, during a recent JCU accreditation process, the Board of the accrediting body disagreed with recommendations made by the accreditation team. In this case, there was a lack of clarity around the process and the University’s options for providing feedback. Within nursing, there is also a lack of clarity around what course changes can be made and reported annually and those that need notification and approval in advance. We understand that some guidelines are currently being prepared by the Accreditation Council to address this lack of clarity.

Recommendation 12: We recommend that a coordinating body (e.g. AHPRA) oversee the development of guidelines to improve the clarity of accreditation processes, including reporting, notification and data collection requirements across all professions.

Recognition of professional skills
We also note a trend towards recognition of the importance of professional skills within the accreditation process. Highlighting and accounting for the teaching and learning of skills such as communication, professionalism, cultural awareness and ethical practice ensures graduates not only ‘know their stuff’ but can also work well with people and communities.

We emphasise our support for this trend, noting that the goal of producing well-rounded graduates is written into accreditation standards.

3.2 Responses to questions:

Input and outcome based accreditation standards

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

There are trends across the different disciplines towards measuring outcomes rather than solely inputs, as can be seen in the new accreditation standards for psychology and medical laboratory sciences. There are good reasons for this. Where accreditation assessment is process- rather than outcomes-focussed, key indicators of success and innovation may be overlooked and unrealistic targets may be set. For example, student/staff ratios may be used as metric to assess course quality, but using this metric alone might overlook innovative learning and teaching approaches (that potentially affect the ratio), Quality Indicators for Learning and Teaching (QILT) and other measures of student success and satisfaction.

We support the shift towards measuring outcomes, but there are a number of circumstances where input and process metrics are warranted. For example, a student who is not given adequate support during a course of study may survive that program but decide not to remain in the profession as a result of negative experiences during their study or professional experience placements. Measuring hurdle
requirements, particularly in respect of English Language, is also critical. In addition, without adequate staffing or processes within a university, a program may be able to produce reasonable outputs but quality of the output will decrease over time.

Overall, there needs to be a balanced mix of input, process and outcome-based standards. We also recommend that all accrediting teams consider performance measures such as QILT and other higher education innovations in the Australian scene in their assessments. We also emphasise a need for the criteria for the outcome-based standards to be clearly defined.

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

Some professions, such as physiotherapy, already have outcome-based standards. In other disciplines, changes will be required. There would need to be extensive testing and review of outcome-based standards to ensure that they achieve their aim and do not disadvantage students or the capacity for development of innovative curricula.

Health program development and timeliness of assessment

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?

Where competency frameworks are being revised or new frameworks developed, a common approach would be sensible as it would reduce overlap and repetition of processes and ensure consistency. However, there would need to be some care taken to ensure that a generalised approach does not erode profession-specific issues. Inclusion of consumers would only be helpful in relation to generic competencies.

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

Overall, we support the development of common accreditation standards for particular elements/domains. Each profession, however, should have control of the development and implementation of the profession-specific requirements.

Benefits:
- Consistency and enhanced certainty of what is required of institutions and accreditation panels.
- Increased efficiency where similar sets of information would only need to be provided once to a single agency (e.g. AHPRA).

Risks:
- There are a number of the standards that would not be appropriate to all disciplines.
- There is the risk that discipline-specific requirements may be overlooked.
- Standardisation allows for a common process, however, runs the risk of losing relevance through standards becoming too broad. This could be alleviated by having a broad set of aspirational standards and industry-relevant pathways for attainment.

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?

We suggest the following changes:
- Establishment of a single coordinating body to oversee and deliver shared functions and planning across all profession-specific accreditation bodies;
• Implementation of a continuous quality improvement cycle for the organisations that accredit programs, allowing for continued changes as the health workforce and training models evolve. Processes should encourage real-time responsiveness to changes in professional knowledge (i.e. constant curriculum modification, as appropriate, should be encouraged and supported);

• Greater flexibility in approaches to inter-professional supervision and supervision requirements which would enable placements within rural, remote, and international settings; and

• Incorporation of a formalised process of industry feedback into accreditation processes, reflecting the whole of industry in terms of the students’ compliance with continuing professional development, research projects and other indicators.

**Inter-professional education, learning and practice**

13. How best could inter-professional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

There is a need for accrediting bodies to recognise the value of inter-professional supervision across all disciplines. Some (e.g. medicine, physiotherapy) already enable this, but others (e.g. clinical psychology) are very restrictive. Lack of flexibility in inter-professional supervision is often a rate-limiting factor for rural, remote and international clinical placements, especially in environments where multi-disciplinary practice is common.

In general, students need to be exposed to multi-disciplinary practice to understand the roles of different professionals within a health team, but it can be difficult for students to conceptualise inter-professional practice if they have not yet consolidated the role of their own professions.

**Clinical experience and student placements**

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

Enhancing linkages between universities and health systems through coordinating research and education activity across geographic regions (i.e. via the establishment of academic health centres, such as the Tropical Australian Academic Health Centre) will assist in enabling greater alignment of healthcare priorities with curricula and clinical experiences. Ensuring that within these curricula there are clear criteria regarding the learning outcomes of placements will also further align healthcare priorities with clinical experience.

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

Injection of relevant contemporary academic ideas and teaching into the clinical placement experiences helps all parties to grow. Involvement of academics in the contemporary practice of their profession helps inform their teaching.

Simulation-based training, specifically, is now included in many programs following the work of Health Workforce Australia. Most disciplines have now added this to their accreditation standards. While simulation, particularly high fidelity simulation, should be counted as part of students’ clinical experience, it should not completely replace real life clinical training experiences in contexts of care relevant to future practice.
The delivery of work-ready graduates

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?

All practitioners need supervised practice prior to full registration. Some disciplines have allowed for this in the length of their programs, while others have recognised that to do this in the university degree will prolong the time spent at university. To have all disciplines move to one model would either increase the length of the degree or mean that more intern/post grad work year one positions would need to be found. It would require a huge and expensive effort to develop post grad year one training positions across both the public and private sectors. Issues to be considered, and funded, include:

- ensuring equivalence of the workplace based training environment;
- training of workplace supervisors;
- developing a common post grad year one curriculum, with teaching and learning resources and;
- remuneration for interns during their post grad year one

In nursing and midwifery, there is no evidence supporting the current minimum hours in Australia or internationally, despite the current minimum hours requirement in the pre-service program being too little. Furthermore, the pressure of contracting academic semesters and the failure of governments to adequately fund clinical placements prevent this situation from being remedied. Properly funding clinical placements so that there can be an expansion of hours would help to provide work-ready graduates. We emphasise the critical need for sufficient high-quality clinical training in contexts of care relevant to future practice, which applies across all health professional disciplines.

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

Work readiness should mean that graduates have met the threshold competency requirements. General skills that are transferrable between workplaces should be taught prior to registration, while workplace training is always going to be required to train graduates for the policies, procedures and clinical context of that particular workplace, e.g. 3° level hospital, primary health care centre. Teaching skills and knowledge particular to one workplace should be the primary responsibility of that employer.

Health services need to recognise their responsibility in respect of education of students and graduates, while graduate programs need to be adequately resourced and seamless. This outcome can be achieved with greater collaboration between educational institutions and health services.

National examinations

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?

We strongly emphasise that national assessment for registration is a step backwards. There is no need for national assessment if students are meeting graduate competency standards. National examinations can lead to education providers teaching to meet the needs of the assessment rather than the principles that are required to be applied in practice. They would limit motivation and ability to tailor programs to meet specific needs (e.g. rural and remote). To assess the clinical skills of all graduates of all professionals at a
national level would also be extremely costly. Furthermore, national examinations would be limited in scope in only assessing theoretical knowledge.
4. Producing the future health workforce

4.1 General comments:

We recommend that the following actions are taken to enhance alignment of accreditation and registration systems with health reform and innovation objectives:

Establish flexible systems that can respond to new health system developments

It is critical that accreditation and registration systems are responsive to Australia’s current and future health workforce requirements.

Responsiveness to national priorities

Key developments include the globalisation of the health sector and the role of health workforce mobility (see Case Study 4), micro-credentialing and the adoption of ‘generalist’ models across the professions. We emphasise the importance of taking a whole-of-population approach to structuring accreditation and registration systems, whereby the health and wellbeing of Australians and our nation’s broader development objectives is put before any profession-led preoccupation with ‘protecting the profession’ such as trends towards increasing specialisation.

<table>
<thead>
<tr>
<th>Case Study 4 – Health workforce mobility</th>
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<td>Globalisation of the health sector is increasing, with a flow of services, expertise, information and people (including health professionals and consumers) being seen across country borders. There is also a growing global recognition that international mobility of health workers may bring numerous benefits to source nations, destination nations and health workers themselves if it is based on ethical norms and standards.</td>
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<td>Health workforce plays a critical role in the ability of nations to meet Universal Health Coverage goals and many nations are unable to provide a stable and effective health workforce in the face of persistent maldistribution and chronic over- and under-supply of health professionals. Freer movement of health professionals across borders will allow nations, including Australia, to better respond to the challenges of maldistribution and fluctuating over- and under-supply, and to meet the health workforce demands associated with ageing populations and a rising burden of chronic disease.</td>
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<td>Health and education represent a significant and growing proportion of Australia’s exports, and facilitating and enabling this growth is a key national priority. Australia’s health services exports grew by 8.7% in 2014-15 to 2015-16, with an overall five-year growth rate of 26.7%. Australia’s education exports also increased 8.3% to $20.3 billion in 2015-2016. As the globalisation of health services and movement of health professionals across country borders increases, Australia will require an accreditation system that is flexible and able to respond effectively and efficiently to these developments.</td>
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<td>For example, Australia’s registration and accreditation systems will need to develop initiatives to reduce barriers to overseas clinical placements for students. Participation in the global health workforce will also require Australia to develop innovative, flexible and standardised approaches to accreditation of overseas programs and registration of overseas health professionals. Furthermore, there is scope for Australia to work collaboratively with other nations to develop reciprocal accreditation and registration arrangements.</td>
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Governance structures

Accreditation system governance structures need to be coherent and facilitate achievement of national priorities. One immediate issue affecting the capacity of current structures to work in the national interest is the provisions within the National Law which give accreditation boards authority to approve or refuse an accredited program of study provided they give ‘reasons for the refusal’ (sections 49 and 51), and without any right of appeal.

For example, an accreditation council recently accredited programs of study within both JCU’s northern Queensland and Singapore campuses, but the Psychology Board subsequently approved only the northern Queensland-based program, rejecting the Singapore program. The decision has immediate impacts for JCU’s Singapore Campus, where Singapore-based students are now unable to access a qualification leading to registration following graduation from a fully accredited program. In this case, the ability of the Board to disregard the decision of the accreditation authority demonstrates that the current legislation is undermining efforts to expand educational offerings overseas.

Recommendation 13: We recommend that a body of work is undertaken to map Australia’s key health system development trends and objectives with the required structure of registration and accreditation systems, so that barriers and enablers to achieving these objectives are identified and an implementation framework developed.

Recommendation 14: We recommend that governance structures for accreditation bodies enable decision-making that aligns with the national interest, and more specifically that the National Law is amended to require accreditation boards to provide reasonable grounds for a decision to approve or reject an accredited program of study, and to enable a right of appeal by the accreditation authority that submitted the program to the board if they disagree with these grounds.

Foster innovation

Accreditation is often seen as a barrier to innovation. Within higher education providers, there is sometimes a concern at discipline level about making course improvements when the course has already been accredited and there is a sense that any changes may jeopardise this accreditation status.

Accreditation bodies may also find it challenging to adjust to variations in how universities organise, especially the business partnering model. Some accrediting bodies have few resources and are dealing with growing numbers of institutions that require accreditation, limiting their capacity to remain at the cutting edge of teaching and learning in their discipline areas.

However, it is imperative that solutions to these impediments and barriers are identified if Australia is to position itself as a leader in health workforce innovation.

Recommendation 15: We recommend that key impediments to innovation within accredited disciplines are identified, and solutions developed to improve the capacity of universities to lead and adopt improvements without jeopardising their accreditation status.

Foster critical thinking skills

In 2016 the number of DTHM students participating in overseas placements rose by 17 per cent. Overseas placements allow Australian health professionals to further develop their knowledge and skills and enhance cultural awareness and sensitivity. In preparing students for these experiences, the focus of education and accreditation needs to be not only on producing work-ready graduates, but also on graduates who have the ability to adapt to change.
4.2 Responses to questions:

**Independence of accreditation and registration**

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?

In some disciplines, such as physiotherapy, the national board meets with the accreditation council and with university representatives to have discussions around areas of mutual concern. This model works well and could be adopted in other disciplines.

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?

Clarity is required here with regard to the phrase ‘greater independence of accreditation authorities’. It is not clear from which body greater independence is sought. If the accreditation authorities are Councils, are they already considered independent of the relevant Board?

**Governance of accreditation authorities**

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

‘Community representation’ is difficult to define, and adequately achieve. It pre-supposes the existence of a homogenous ‘community’. Community representation is better placed in the development of curricula leading to a standard that requires a ‘consultative committee’.

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?

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?

Separate committees with clear terms of reference and discrete funding streams may enable adequate separation of these responsibilities.

**Role of accreditation authorities**

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?

**What other governance models might be considered?**

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;

We do not support this suggestion.

Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.
We support the establishment of a single coordinating body which has the authority to provide policy direction on accreditation framework development, as well as guidelines on how to develop coherent standards. Capacity to approve accreditation standards, however, must rest with the professions.

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

Accountability and performance monitoring

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?

The quality of the graduates is the ultimate measure of performance but evaluation of satisfaction of the accredited institutions and financial performance of the accrediting authorities are also important measures. This monitoring and reporting should be undertaken by AHPRA.

Setting health workforce reform priorities

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

Currently the process is lengthy but there is some security in it being regulated by the national boards. The final player in the process should be the relevant Board.

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

The relevant Board should be entrusted with ensuring the quality and relevance of the accreditation standards. The current directive is adequate.

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

As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?

Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

The disestablishing of Health Workforce Australia saw the loss of a number of these functions that need to be recovered.

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

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, they do not. Greater regulation of credentialing activities is needed.

Assessment of overseas health practitioners
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, there are no reasons. A single set of criteria could be developed that satisfies both of the current processes.

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?

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

There is no standard approach in Australia to the assessment of the qualifications of international health professionals seeking to work in Australia and the subsequent registration of these professionals. Qualification assessment processes differ across professions (for example, medicine and physiotherapy recognise some programs as ‘approved programs’, holders of qualifications from non-approved programs may apply to have their qualifications assessed (physiotherapy) or sit an examination (medicine)).

Participation in the global health workforce will require Australia to develop innovative, flexible and standardised approaches to accreditation of overseas programs and registration of overseas health professionals. Furthermore, there is also scope for Australia to work collaboratively with other nations to develop reciprocal accreditation and registration arrangements.

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?

Grievances and appeals

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

37. If an external grievance appeal process is to be considered:

Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?

No, we suggest that the timeframes leading to a decision would be too long. An AHPRA-facilitated accreditation office would be the appropriate place to develop clear guidelines for appeals of accreditation decisions.

Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

Yes, fees are charges are not the only issues that can prove problematic in respect of accreditation.