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Faculty of Medicine, Nursing and Health Sciences
Submission on the Discussion Paper – Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme (NRAS) for health professions February 2017

Thank you for the opportunity provide a submission on this important matter. This submission is from the perspective of academic coordinators of health professions courses at Flinders University and therefore focuses only on the consolidated list of issues numbers 1-18 as these are the issues this group has the most experience of and deepest insight into. The numbering below aligns with the issue numbers in the discussion paper.

1. There would be potential benefits to a greater consistency and commonality in the development and application of accreditation standards. These include speaking a common language within the Faculty across disciplines when talking about accreditation processes and standards; alignment between disciplines within the Faculty so that the disciplines can work together to evaluate programs and share resources; and more standardisation of processes across the Faculty with respect to accreditation which would allow for reporting structures within the Faculty to more closely align with those required for accreditation.

2. The recognition of TEQSA decisions should be prima facie evidence for accreditation. This would mean that any criteria already satisfied for TEQSA and the Higher Education Standards Framework should not need to be replicated for accrediting authorities. This would significantly reduce the burden for universities of multiple overlapping regulatory regimes.

3. The risk management approach can be less burdensome and more cost effective for the accreditation authority enabling them to focus on providers deemed to be at higher risk. The education providers can also benefit as the risk management approach moves away from the rigid accreditation cycle and towards a more responsive, timely change management process. This approach may also lead to reduced costs which will particularly benefit the smaller disciplines/professions and release resources for ongoing educational improvement.

Current accreditation processes involving site visits by accreditation teams provide a number of benefits that should not be overlooked. Some health science programs benefit from strong external professional perspectives and the national overview that professional accreditation provides. Links with professional bodies and the community are also sometimes strengthened as part of current processes. Any move towards risk based accreditation would also need to consider these aspects to ensure they are not lost.
4. The recommended over-arching principle is that teams need to contain the appropriate mix of skills to be able to competently undertake the task. Therefore, skills-based rather than representational selection would be more appropriate. In particular, teams must include members who are knowledgeable of and qualified in higher education pedagogies. All team members must be competent in assessing if the standards have been met as their decisions could have major consequences for the community, provider and other stakeholders. It therefore follows that assessment team members should be appropriately trained and remunerated to undertake this important work.

5. As outlined above, a broader assessment team membership is supported if members are appropriately qualified, trained and remunerated. Assessment panel membership should reflect the terms of reference for that program and skills sets appropriate to evaluating the specific standards being assessed should be engaged. When it comes to involving community members in a meaningful way, thought could be given to the establishment of Community Advisory Groups rather than appointing a lone community member on an accreditation assessment team. Many courses already have these groups in place which results in regular ongoing consultation with a range of community representatives resulting in rich interaction. The requirement for such groups could be considered for inclusion in the accreditation standards.

6. Key principles for consideration include:
   • consistency and equity across health professional programs;
   • accreditation services should be not-for-profit and cost neutral.

7. The Faculty supports a transparent, fair, and reasonable approach to fee setting for this service. Given their role as a public good, all accreditation services, be they for education programs or overseas qualifications, should be not-for-profit and cost neutral.

8. Accreditation standards should only be expressed in outcome-based terms. It is the outcomes that ensure public safety and there are multiple process appropriate for a local context by which an outcome may be reached. Furthermore, outcome-based terms allow the flexibility to respond to changing educational needs and contexts. Process standards can be important but these are rigorously covered by TEQSA so accreditation standards should focus on outcomes.

9. It is recommended that each discipline review the alignment between current assessment processes and an outcome-based framework.

10. The domains of the competency frameworks provided as examples describe the same competencies in different ways. As stated (Discussion Paper pg20) the Threshold Learning Outcomes (TLOs) for Health, Medicine and Veterinary Science (2011) capture this commonality and provide a sensible and considered approach to alignment of the competency frameworks for health professions. This would increase the efficiency of accreditation in the university
context by standardising the fundamental skills and knowledge that all health professional programs would be required to report against. Nevertheless there will need to be allowance for discipline specific competencies and models of training.

A common approach to the development of professional competency frameworks, including consistent timing of reviews, description of broad stakeholder participation and a uniform development process would be more efficient and would ensure appropriate and timely consultation and framework development. The appointment of an independent group to manage these processes would negate any conflict of interest that might arise during the authorship of competency frameworks. Ownership of the competency frameworks should be standardised.

11. The risks are loss of recognition of the specific skills and attributes that each profession contributes to health care and the diminution of the uniqueness of professions. Outcomes based accreditation would require a comprehensive description of the fundamental and profession-specific skills and knowledge to support innovative development of health professions that are able to meet changing healthcare needs. The benefit would be standardised foundations based on TLOs with common shared language and outcomes for all health professions. This would facilitate interprofessional practice and shared codes of conduct, and should support the expectations of employers and consumers.

12. A more nimble and flexible process is required. Changes could include timely turnaround of documentation, decreased replication of documentation requirements, devolution of TEQSA requirements to the University as governance processes which are pre-requisites for accreditation, and outcomes based accreditation which is not prescriptive of inputs and acknowledges there are numerous pathways to the same result. Feedback from employers and graduates after graduation, which could be captured as part of the registration process, would enable evaluation of the knowledge, clinical skills and professional attributes of the workforce. The timing, broad stakeholder involvement and process of competency framework reviews has the capacity to address these issues.

13. The Faculty supports the concept of a national coordinated approach to interprofessional education (IPE), the adoption of the interprofessional learning competencies as graduate outcomes and the adoption of the TLOs for Health, Medicine and Veterinary Science (2011) as an accreditation requirement of all health professions to support IPE. A definition of IPE is required that demonstrates the essential value of IPE as well as interprofessional practice during placement. Accreditation changes which acknowledge cross-discipline supervision, teaching and assessment as a valuable learning experience could be required.

14. We firstly note that some health disciplines perform necessary roles across a range of societal areas of need, not just traditional healthcare settings such as acute hospitals, and therefore the outcomes for a discipline need to be relevant to varied destinations. An accredited pre-registration degree is just the beginning of a probably long career as a health professional and across this time span healthcare priorities will probably change. Therefore, graduates should have skills that make
them adaptable and flexible to respond to current and future healthcare priorities and this capacity could be captured in outcomes-based standards.

15. In an outcomes-based system, the demonstration of competence against the standard would be the measure and this might be demonstrated through simulation or other contemporary education practices. Therefore, the best way to allow a variety of practices would be to focus on outcomes rather than process.

16. From an educational perspective, a period of supervised practice as a pre-condition of general registration, is neither fish nor fowl. Either it is a learning phase (which would be logical because one has not got general registration yet) and therefore every graduate should be guaranteed a place because it is unethical to cut short an educational process when the student has already invested so much time and money into it. Or, it is a work phase in which case registration happens at the end of the university degree. We think there is a need to thoroughly and conceptually revisit the whole internship process and bring it into 21st century education.

17. The notion of work readiness assumes that ‘work’ is an immobile starting line that one can reach. In reality, health practitioners operate in an environment of expanding knowledge and rapidly changing practice. In this context, no professional is ever truly ‘ready’ but is instead constantly learning and adapting. This places the onus on employers to provide induction, transition to practice, and ongoing training throughout the career of a health professional. The responsibility of courses is to provide graduates who are ready to engage with the initial and ongoing training and who are responsive to a lifetime of learning.

18. Accreditation of courses does negate the need for a national assessment. A national assessment invariably means a national examination which would be detrimental and we provide here a detailed rationale.

If one were to take a public health perspective then one could see a national examination as like a national screening program for the disease ‘bad curriculum’. Before a large investment is made in national screening programs in public health four questions need to be addressed:

1) Is the disease prevalent enough – likely enough to occur – for the screening program to be useful. As every diagnostic tool – and an examination is a diagnostic tool – will lead to false positives and false negatives, diseases that have a low prevalence have a very high likelihood to be falsely ‘detected’ with all the negative consequences. Given the rarity of a ‘bad’ course or graduate, especially in Australia’s TEQSA-regulated university system, the false detection rate would be unacceptably high. Given the already rigorous quality assurance around curricula through the accreditation process, a national test would cost a lot and lead to extremely little gain.

2) Is the screening test sensitive and specific enough to pick up the 'disease'. No national test will be able to pick up underperforming courses. It has long been known and described in the literature and any one-off test is simply far too insensitive and far too susceptible to bias to pick up underperforming courses. Even the collaborative progress test in the Netherlands, which is based on four tests per year for all medical students of all year classes and where all the curricula are six years undergraduate entry and therefore comparable, is barely able to pick up meaningful
differences. And even if it does, it is still only in the knowledge domain. Knowledge is an important prerequisite for success for problem-solving, but those issues that concern the public most at the moment have very little to do with factual knowledge and more with transgressing boundaries or poor communication. National testing would not be likely to pick up more than the factual knowledge bit and even with a national practical examination we would be investing in developments of the past which are on their way out, instead of investing in the future of assessment.

3) The third question relates to whether something can be done about the 'disease' when it has been picked up in the screening process. Screening just to make a diagnosis without a very concrete plan as to how to treat it is useless. At the level of a curriculum the outcome of national testing can only inform the curriculum as to where they are in a sort of national ranking, but absolutely no information is provided with respect to how to improve. An accreditation process is far more effective in this. At the individual student level we have to realise that the decisions made on rather simplistic national tests are extremely high stakes and it is just a matter of time that clever students will do the maths and find out that their pass/fail decision is based on thin data with poor measurement qualities. Typically, exams like this are unable to reach acceptable ($p \leq 0.05$) error margins for such high-stakes decisions, even with high reliabilities. Given the fact that students are usually required to pay fees for their education, is very likely that legal challenges will happen, and would probably succeed. The costs associated with the likely litigation would be enormous and entirely unnecessary.

4) The final question pertains to what is the number needed to treat or the number needed to harm. Every diagnostic tool is imperfect and every preventative treatment has to be done on large groups of individuals without knowing for whom individually the treatment will prevent a certain disease and for which there is likely to be harm associated with a screening program. The analogy is that national assessment may not be perfect but everybody understands that national assessment has negative consequences such as: teaching to the test, students strategically preparing for the test and curriculum changes at the expense of competencies that have nothing to do with what the test tests but which are extremely important for patients, such as communication, collaboration, professional behaviour, health advocacy, etc., etc.

There are also financial arguments to be made. The setting up of a national testing system is a multi-million dollar endeavour with very little gain. If we look at the costs associated with the running of the Medical Licensing Examinations in the US, they are enormous. Even the US National Board of Medical Examiners in their start-up phase preferred to set up a national accreditation system rather than a national test system. They saw the huge advantage of having an accreditation system for the improvement of quality of medical education in the country. However, at that time – the early 20th century – the number of bad medical schools in the US was high and the system needed to be in place to quickly remove accreditation of those medical schools. They have since become trapped in that system as it is extremely difficult to undo national testing once it is in place. The US starting context was totally different to the one that currently exists in Australia and therefore not relevant. The money that is invested in setting up a national assessment system with such little gain would be much better be spent on improving the quality of higher education in the health professions in Australia. Australian higher education has served as an export product which is currently suffering, at least in health professions-orientated curricula, from
disinvestment and is increasingly lagging behind compared to the investments and quality improvements that are taking place in the countries around us from which we traditionally recruit international students. Investing money in national assessment would lead to a further disinvestment in quality improvement of the industry. Clearly, we strongly advise against the development of any form of national assessment and look instead to the international literature showing that a rigorous accreditation process is far better.

We would be pleased to discuss the submission above, or any other parts of the discussion paper.