Background for submission

Concerns regarding practitioner regulation for health professionals outside of the National Regulation and Accreditation Scheme (NRAS) have been explored both nationally and within some jurisdictions. Concern has been raised by professionals and consumers alike, expressing significant interest in the need for quality assurance and national consistency for services provided by the professions outside of the 14 covered by NRAS and the Health Practitioner Regulation Law.

The National Alliance of Self Regulating Health Professions (NASRHP), under the auspice of Allied Health Professionals Australia (AHPA), has long acknowledged this and through submissions to various national bodies over time have expressed both concern and lobbied for inexpensive and effective options to remedy this for self-regulating allied health professionals and the safety of Australian health consumers.

In 2010 it became apparent that there was a reluctance to extend the newly operating NRAS to incorporate further professions. At this time founding NASRHP organisations commenced working together to benchmark their regulatory standards. In late 2011, an opportunity was identified for NASRHP member organisations to jointly investigate a model that supported the growth and evolution of the professions they represented. Published in March 2012, Harnessing self regulation to support safety and quality in healthcare delivery presented a comprehensive model for regulating all health practitioners, within which NASRHP’s objectives were stated as:

- Seek clarity regarding regulation for their respective professions
- Benchmark their self-regulatory environment
- Advocate on behalf of the public for an improved health regulatory environment
- Address the challenges and consequences for the professions and health agencies of the current fragmentation in health practitioner regulation.

Between 2010 and 2014 the NASRHP scoped and undertook development of a framework of common, best-practice standards which should be applied to Australian national peak professional bodies of self-regulating allied health professional associations.

In 2014 the NASRHP made a submission to the Commonwealth review of the NRAS, contending that to protect the interests and safety of the public a single national authority such as the Australian Health Practitioner Regulation Agency (AHPRA) should be responsible for managing the regulation of all health practitioners. This requires an integrated framework covering the registered professions, authorised self-regulating professions and negative licensing of those practitioners who do not otherwise fit within the regulation processes.

This submission sought:
• The national law be amended to include a description of self-regulating health professions for inclusion under the NRAS.
• Authorised self-regulation, with reserved/protected title legislation, will require practitioners utilising the protected title to meet standards for practice set by the professional association. All regulation will be managed by AHPRA and the framework will be fluid, such that on AHPRA’s recommendation a profession may move out of or into the NRAS should its demonstrated risk profile change.

In August 2015, Australian governments responded to the recommendation of 2014 review of the NRAS. In their response, they have deferred any further discussion of including additional professions under the NRAS, and rejected the recommendation to establish a system of quality assurance for voluntary registers of self-regulated professions.

Following years of consultation, scoping and development, the National Alliance of Self Regulating Health Professions (NASRHP) proposes to provide assurance to consumers, government and other entities regarding the safety and quality of self-regulating health services, through the establishment of an evidence-based national framework of regulatory standards.

These standards will be applied by an independent body to approve those Australian peak professional bodies who meet the standards to self-regulate and accredit practitioners within that profession. This will facilitate national consistency in quality and support for self-regulating health professionals and satisfy national and jurisdictional regulatory requirements, including the National Code of Conduct for health care workers and associated jurisdictional mechanisms, as well as extend practitioners to achieve high quality and evidence-based professional standards.

A proposed Governance model and framework composed of the following eleven standards has been developed by NASRHP:
• Scope (Areas) of Practice
• Code of Ethics/Practice and/or Professional Conduct
• Complaints procedure
• Mandatory Declarations
• Professional Indemnity Insurance
• Competency Standards
• Practitioner Certification Requirements
• Course Accreditation
• Recency and Resumption of Practice Requirements
• English Language Requirements
• Continuing Professional Development

The National Alliance of Self Regulating Health Professions (NASRHP), now and incorporated body, is committed to providing assurance to consumers, government and other entities regarding the safety and quality of self-regulating health services, through an evidence-based national framework of regulatory standards. Regular membership ensures that the commitment has been translated into practice. It is an opportunity for NASRHP and
Professional Bodies to communicate openly on issues relevant to self regulating health professions.

Founding organisations:

- Audiology Australia
- Australian Association of Social Workers
- Australian & New Zealand College of Perfusionists
- Australasian Sonographers Association
- Dietitians Association of Australia
- Exercise & Sports Science Australia
- Speech Pathology Australia
- The Australian Orthotic Prosthetic Association

General Comments
Although the founding organisations of NASRHP are not part of NRAS, NASRHP looks to ensure the same level of standards and quality assurance applies.

Several elements within the review will have a role on effect with the self-regulated professions, thus it is important to consult with NASRHP regarding the potential changes to Accreditation Systems within NRAS.

Improving efficiency

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

If consistency in the development and application of accreditation standards exists, universities would also want registered and self-regulating professions to have consistency.

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?

Duplication and overlap should be avoided.

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

Nil comment.

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 interprofessional collaboration?

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

Nil comment.

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?

Nil comment.

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?

Nil comment.

Relevance and responsiveness

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?

Developing accreditation standards that are based on what a new graduate can competently do is important. Thus, having outcome based competency standards is important. Demonstrated competency of graduates also continues to hold importance.

Some input standards may be required if there is a need to ensure the standards are delivered in a particular way.

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

Nil comment.

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?

As universities are looking to standardise the work across their departments/schools, if NRAS is looking standardise those professional competency frameworks for the registered professions, universities would be looking for the self-regulatory professions to be similar. If this is the direction to be taken, consultation with the NASRHP is required.
11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

If NRAS is looking have common health professional elements with the registered professions, having consistence with the self-regulatory professions should be considered. If this is the direction to be taken, consultation with the NASRHP is required.

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?

Graduates may be employed in a variety of work settings within a rapidly changing health sector. Some graduates may also apply their skills and knowledge in industries related to health, for example dieticians working in the food industry. Consequently, accreditation systems should support production of graduates to meet the needs of an evolving workforce. Ideally, courses should be required to review their accreditation every 5 years.

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?

Inter-professional learning is important for graduates and there needs to be a greater promotion of inter-disciplinary practise within accreditation standards. Caution must be given to ensure that inter-professional education, learning and practice is not limited to just the collaboration of the registered professionals, but also the self-regulated 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?

As universities are looking to standardise the work across their departments/schools, if NRAS is looking to standardise clinical experience for the registered professions, universities would be looking for the self-regulatory professions to be similar. If this is the direction to be taken, consultation with the NASRHP is required.

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

The self-regulated professions seek funding opportunities to support the development of simulator-based education and training.

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?

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

Nil comment.

**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?

Nil comment.

**Producing the future health workforce**

**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?

Nil comment.

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?

Nil comment.

**Governance of accreditation authorities**

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

Nil comment.

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?

Nil comment.

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?

Nil comment.
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?

Nil comment.

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;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

Nil comment.

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

Nil comment.

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?

Nil comment.

Setting health workforce reform priorities

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

Health workforce reform should not just be a focus of the registered professions. Registered professions are normally the first professions to be considered in any health workforce considerations and the self-regulator professions are the last.

Any role should also be expanded to the supporting the self-regulatory professionals also.

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?
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?

Nil comment.

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?

Nil comment.

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?

Assessment should be aligned. Otherwise there may be a risk that skilled workers are in the country who are unable to obtain registration, or that the requirements unnecessarily restrict skilled migrant entry.

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

No, these are the best placed organisation to undertake the skills assessments

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

Nil comment.

35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

Yes, this would lead to less demand on supervision
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?

Nil comment.

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

- Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
- Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

Nil comment.