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

Optometry Australia Submission

April 2017

Optometry Australia welcomes the opportunity to provide comment on the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions.

Optometry Australia is the national peak professional body for optometry, and represents the largest community of optometrists in Australia. Since 1918 we have united the sector to make Australia a world leader in the delivery of vision and eye health services and patient care. Our focus is to lead, engage and promote the profession of optometry, optometrists and community eye health.
Rather than addressing the full range of questions listed in the review discussion paper, we will concentrate our comments on the following main areas:

- Accreditation standards
- Accreditation Cycles
- Profession specific knowledge
- Consumer representation
- Independence
- Ministerial intervention
- Costs
- Australia and New Zealand

Accreditation standards

The Optometry Council of Australia and New Zealand developed the Accreditation Standards and Evidence Guide for Entry-Level Optometry Programs Part 2 – Standards (the Standards) that became effective on 1 January 2017. The Standards “recognise contemporary best practice in standards development across Australia and internationally, where there is a strong shift away from ‘inputs’ towards patient and learner centred ‘outcomes’.”¹

The Standards comprise five broad domains, which are categories likely have applicability to all health professions:

1. Public Safety
2. Academic Governance and Quality Assurance
3. Program of Study
4. The Student Experience
5. Assessment

Within each domain, there may be areas of commonality between health accreditation councils in terms of policy, need for evidence based practice and accreditation principles. (It is difficult to determine similarities and differences between professions’ accreditation standards without a thorough mapping exercise.) However, within each domain there are also important standards specific to the profession, in this case optometry. It is important to ensure these are maintained through profession-specific accreditation standards. Given the specific nature of these, it is important for professions to maintain their independence and autonomy with regard to the determination of accreditation standards.

Whilst there may be some benefits in combining some functions under a single accreditation entity this is likely to primarily be useful only in terms of minimising duplication of business processes and costs, the provision of administrative consistency, and the provision of evidence-based policy level support that can be drawn on to strengthen the work of accreditation bodies. Beyond that, we need to maintain, and indeed strengthen, the capacity for each health profession to maintain a body that makes its own determinations in relation to specific content of accreditation standards, with their interpretation and application based on and reflecting the very specific experience of those professions. We do not believe that all accreditation functions could be appropriately overseen by a single entity, given the specific and different needs of professions and entry-level courses, and would not support such a proposal.

It is important to note that there are a number of mechanisms to acquire qualifications within the different professions. Some are a single course where the full curriculum and learning to which the student is exposed are known; others are post graduate courses that build on prior learning (that may have occurred at a different institution.) It is difficult to see how a single accreditation authority would be able to manage these differences across a range of professions.

**Accreditation Cycles**

Potentially, the timing of accreditation visits could be based on risk or be cyclical. Ideally, we believe, these should not be mutually exclusive approaches. All cycles of accreditation should operate with a risk-mitigation approach. We are confident that the accrediting body in optometry currently implements such an approach.

We believe that risk evaluation criteria and cycles for review should not be altered arbitrarily, and that a one-approach-for-all professions policy would not be appropriate. Any changes should be based on current evidence of good practice, and a fair assessment of the processes currently in place for each NRAS profession, to determine the extent to which that profession would or could benefit from a shift from one focus in strategy to another. Factors such as course length, the costs associated with accreditation, and disruption to education providers and students all need to be considered when thinking about the timing and frequency of accreditation cycles.

In addition processes may need to be different for new courses where it may be most appropriate for a number of accreditation visits or communications to occur as the course develops.

We suggest it is appropriate that reporting of major changes within a course and other factors may trigger further assessment from an accreditation council or body, although this need not necessarily be in the form of a full accreditation visit.

We further suggest, if there are considered to be risks within a particular course, conditions to accreditation should be able to be introduced, with these needing to be addressed within a certain time frame.

**Profession specific knowledge**

We believe that profession-specific knowledge within an accreditation council is paramount.

With respect to assessment panels, we believe that these must be profession-specific and comprised only of members of the relevant profession. A health professional from outside the course’s profession would be unlikely to be able to fully assist in an accreditation visit of that course; for example, they would be unlikely to be able to comment on appropriateness of course material, the access students within a course have to equipment or on the suitability of clinical placements. It is likely to be a poor use of resources to have an accreditation team member from outside a profession who is unable to assess the majority of accreditation standards. This is not to say that members of other professions should not be encouraged to contribute to accreditation decisions in other ways, such as, where relevant, being able to make submissions regarding accreditation or being interviewed as part of the accreditation process.
Given the importance of assessment panels comprised of members of the relevant profession, there appears to be limited value in cross-professional training of accreditation teams. Cross-professional training may be appropriate to areas of commonality (eg. confidentiality of material and interview procedures) and where there is a common year across professions, but the need for profession-specific training will also remain.

**Consumer representation**

We do not consider that there is a need for consumer representation in the specific activities of the accreditation process, where that consumer is a member of the general public or a representative from a consumer organisation. At the level of accreditation of training, consumer input is difficult to integrate as the needs of the curriculum, facilities and so on are not directed to the consumer, but to the student and ensuring their development as competent health professionals. In the context of accreditation, students may be the more relevant consumer/user group.

We therefore consider that there needs to be relevant consumer representation in terms of students and graduates from a course, practitioners involved in clinical placements or employers of graduates from a course. We suggest this representation should not be as a member of the accreditation team but as a group offered avenues to contribute to accreditation consideration through a submission or interview discussion. Currently, and we believe appropriately, students, graduates and employers of graduates have opportunities to make a submission or be interviewed in optometry accreditation processes.

Whilst in terms of community representation in key accreditation decisions there is likely to be very limited benefit and little need, there is likely benefit of health care consumer input to the determination of competency standards or accreditation standards, for example to ensure consumer-directed care, appropriate communication skills and culturally-sensitive approaches to care.

**Independence**

We consider that it is essential that accreditation councils are autonomous. This is an important component in ensuring that accreditation decisions are, and are recognised as, independent and unbiased. As noted above, there may however, be scope for centralised support in terms of areas such as administration and accounting.

We are not of the view that there are currently concerns about independence as a consequence of the current accreditation system, as accreditation councils are autonomous bodies.

As the Optometry Board of Australia reports, the “Optometry Council of Australia and New Zealand is the accreditation authority responsible for accrediting education providers and programs of study for the optometry profession” ([http://www.optometryboard.gov.au/Accreditation.aspx](http://www.optometryboard.gov.au/Accreditation.aspx)). The Optometry Council of Australia and New Zealand has developed accreditation standards for optometry courses. (The Optometry Board of Australia website reports that “The following guidelines are published in accordance with section 47(6) of the Health Practitioner Regulation National Law (the National Law) as in force in each state and territory. The guidelines are the approved accreditation standards, as defined under section 5 of the
National Law, for the optometry profession. The approval for these accreditation standards was made under the transitional provision in section 255 of the National Law.” The documents then listed are those developed by the Optometry Council of Australia and New Zealand.) We are aware that the process the Optometry Council of Australia and New Zealand employs in developing these standards includes broad consultation with stakeholders, including representatives of the optometry profession.

The review seeks views on whether 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. We note that expertise of the National Board in any area is dependent on the composition of the Board at any time and their preparedness to consult outside the Board on relevant issues. The Optometry Board of Australia currently includes people with expertise in optometric education and accreditation. However, in optometry the accreditation function is delegated to the Optometry Council of Australia and New Zealand who maintain expertise in accreditation at all times. The Optometry Board of Australia does have the capacity not to accept recommendations made by the Optometry Council of Australia and New Zealand in terms of accreditation, but they offer informed, expert advice following accreditation assessment (“Once accreditation is granted by OCANZ, the Optometry Board of Australia (OBA) and the Optometrists and Dispensing Opticians Board New Zealand (ODOB) must approve the decision before the program becomes an approved program of study for the purpose of registration in Australia and New Zealand” (From: www.ocanz.org/accreditation).)

Ministerial intervention

The review questions whether “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?”

We cannot see what current or future circumstances would require capacity for ministerial intervention, if a strong registration and accreditation system is in place. Moreover, this capacity comes with the risk of politicising aspects of the accreditation process, which is not on our view outweighed by the examples provided in the review discussion paper, which are all matters that should be able to be handled through a robust accreditation approach using evidence-based principles as outlined above.
Costs

Currently not all councils undertake every aspect needed for accreditation of courses. Alterations to the structure and oversight of accreditation councils may alter costs with the potential of introducing additional costs.

For example, in optometry, Optometry Australia bears the cost of the development of the entry-level competency standards for the profession; these standards are then made available to the Optometry Council of Australia and New Zealand (as well as the Optometry Board of Australia) at no cost, for use as needed. The Optometry Council of Australia and New Zealand uses these standards as part of their accreditation process. If the development of these standards were added to the role of the accreditation council, whether as an independent council, or as a sub-committee of an overarching accreditation council, there would be considerable costs incurred for their development or review.

Australia and New Zealand

It should be noted that in the profession of optometry, the Optometry Council of Australia and New Zealand needs to consider the New Zealand situation as well, in terms of accreditation and registration requirements. This has been the case for a number of years and reflects co-operation between the Optometry Board of Australia and the Optometrists and Dispensing Opticians Board (New Zealand).

Consideration needs to be given to Trans-Tasman Mutual Recognition in determination of accreditation functions, since currently, for instance, the Optometry Board of Australia accepts the accreditation of the optometry course in New Zealand by the Optometry Council of Australia and New Zealand, with graduates from that course being eligible for registration in Australia. (Similarly the Optometrists and Dispensing Opticians Board (New Zealand) accepts the accreditation of Australian courses by the Optometry Council of Australia and New Zealand as indicating that graduates are suitable for registration in New Zealand).

Any changes to the oversight of accreditation councils need to address the issue of Trans-Tasman Mutual Recognition.