OCANZ Response to AS Review

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Executive Summary

This submission by the Optometry Council of Australia and New Zealand (OCANZ) to the February 2017 Accreditation Systems Review discussion paper addresses in order the three themes set out in the discussion paper: improving efficiency, relevance and responsiveness, and producing the future health workforce, while having regard to limitations which may be required by safety and quality principles. In the next section of this summary, we list the OCANZ replies to those of the 37 review questions we have specifically answered and refer the reader to relevant parts of the body of our submission for further details.

The OCANZ response to the Review overall is that the existing systems are, in the main, delivering flexibility and responsiveness in the development and delivery of educational programs in optometry and are producing a responsive and sustainable optometric workforce.

OCANZ recognises the need for and supports various incremental improvements to deliver a more sustainable health system in the public interest. In particular, this includes paying greater attention to cross-profession and multi-profession issues through revised governance.

In relation to improving efficiency of the processes involved in the accreditation of programs of study and their providers, the submission reports on the positive experience of OCANZ in constructing common approaches to the development of accreditation standards, processes and training materials for assessment teams rather than supporting the distillation of common outcomes which may reduce flexibility and innovation. We also argue that risk-based approaches and cyclic evaluations are not mutually exclusive: cyclic evaluation adds a macro-approach to the overall system within which risk-based assessment is a core tool. The OCANZ experience is that profession-specific input, as opposed to cross-profession considerations, is paramount in relation to the interpretation of standards for a specific profession.

On the question of the relevance and responsiveness of health education to meet the emerging needs of the community, the submission provides evidence that innovation in the training of the optometry workforce is already occurring and is not being impeded by OCANZ accreditation processes. OCANZ embeds principles of maximum indifference to forms of flexibility and educational innovation in our regulatory approach, while maintaining the safety focus, providing strong productivity against reasonable cost.

With respect to the appropriate governance and accountability to produce the future health workforce, OCANZ does not consider that there is evidence that fundamental reform of accreditation systems governance is: required; cost effective; or will necessarily deliver a more sustainable health system in the public interest than the current arrangements. There are potential risks arising from significant change including the transition costs, possible loss of peer support and removal of consistency in accreditation functions between Australia and New Zealand.

Finally, we present evidence that OCANZ meets the requirements for internal independence from sectional interests and involves consumers to ensure that the public interest remains paramount. However, we recognise that the current accreditation system is missing a centralised transparency and accountability committee which can oversee and promote inter-professional cooperation between the various agencies and other participants and deliver disinterested commentary on the
overall efficiency of the system. We would also welcome further direction from government on its workforce reform agenda, including a review of workforce supply and demand.

Summary of responses to review questions addressed by OCANZ

Improving efficiency

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

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

The benefits of common approaches outweigh the costs as long as profession-specific considerations which may impact on safety and quality are not compromised by lowest common denominator standards/processes. See submission pages 10-11.

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?

The assessment processes of TEQSA and accreditation authorities align and do not overlap; decisions by each party should be taken into account by the other party to the extent they overlap and are relevant to the requirements of each body. See submission page 11.

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

Risk based approaches and cyclic evaluations both benefit safety and quality and are not an either/or proposition. See submission pages 12-14.

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?

OCANZ already uses training materials/tools in common with other Accreditation Councils and is happy to support greater process consistency and collaboration, see submission pages 14-15.

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

There should be strong consumer involvement, not necessarily through this mechanism. See submission page 14.

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?

The key principle is that fees charged should remain reasonable having regard to the efficient and effective functioning of the Scheme and the key goals of maintaining safety and quality. All users should contribute to accreditation, that is: registrants; education providers; and, recognising the public benefit of safe and competent health practitioners, governments. See submission pages 16-18 which outline how OCANZ currently determines respective income shares.
Relevance and responsiveness

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

The focus should be on outcomes, however outcomes versus inputs/processes is not an either/or proposition, particularly in the case of new programs of study. See submission page 19.

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?

OCANZ can see the merits of introducing a policy to guide consistency in the process of developing professional competency frameworks to be used for accreditation purposes in the regulated health professions. See submission page 20.

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

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

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

See submission pages 22-24, which argues that these issues are already embedded in optometry programs and are explicit criteria in the OCANZ accreditation standards.

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?

OCANZ considers that valid and reliable assessment methods are best evaluated within the overall context of assessment in the specific program of study. This is alignment to the risk-levels of particular professions/programs of study, rather than alignment to an abstract uniform standard. OCANZ is not persuaded that national examinations are an efficient or effective way to determine the educational quality of programs of study in optometry. See submission page 21.

Producing the future health workforce

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

Yes, and flexibility in approach as to how to involve community representation should be maintained. See submission page 14.

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real/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?

See submission page 27 which argues that OCANZ company objects are fully aligned with the accreditation requirements of the National Law and that no particular changes are necessary. We note that accreditation activities are commercial obligations, subject to the terms agreed in contracts.
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?
26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?
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?
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? And has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

To provide additional oversight of all of the above functions, OCANZ proposes the establishment of an additional governance structure, see submission page 28.

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?

In the case of optometry, the processes are mostly aligned. The only variation is the process for certifying for skilled migration visa purposes the standing of those who have qualified in optometry through study in an accredited Australian/New Zealand program of study.

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

No. See submission page 29.
Introduction and Overview

The Optometry Council of Australia and New Zealand (OCANZ) is pleased to make this submission in response to the discussion paper which forms part of the independent review of accreditation systems within the National Registration and Accreditation Scheme (NRAS) for health professions (the Review).

At the outset, OCANZ recognises the challenging task faced by the Review: of evaluating the current system, and considering the sensitivity of the system to any changes.

In particular, we recognise the critical tension between the principal goals of health regulation under the National Law (safety, quality and trust) and the broader desire to ensure both regulatory efficiency, and adequate health workforce supply.

OCANZ notes that the discussion paper asks key questions related to the governance, accountability and consistency of operation of the accreditation functions covered by the Scheme in Australia, and the capacity of these functions as currently constituted to support the future health care needs of the community.

We have addressed the various issues raised in the discussion paper thematically under the three headings identified by the Review. In considering each question, we have sought to honestly dissect where OCANZ meets or has yet to meet the broad goals of accreditation, while having regard to limitations which may be required by safety and quality principles.

The central message we would ask the Review to take from this paper is this: currently OCANZ delivers an increasing annual supply of fully-qualified optometrists, within an extremely flexible educational framework. Given that the guardianship of public safety lies with OCANZ as the gatekeeper of common standards, relaxing or oversimplifying oversight of the profession risks market entry by people who only resemble safe and appropriately-qualified optometrists. Efficiency is no substitute for trust.

Our approach permits what we see as the maximum level of educational variation, and market competition permissible, within the confines of consistent and safe competence to practice optometry. While this may superficially provide a barrier to entry, we believe our approach actually maximises both innovation and market supply.

Within this submission, we have considered some key costs and comparators as markers of efficiency. However, we have not undertaken a full cost-benefit analysis, which we expect will be part of the Review team’s activities. We have participated to date in the work of the Costings Working Group (CWG) which represents the 14 professions regulated by the Australian Health Practitioner Regulation Agency (AHPRA) and would be pleased to provide other data and commentary which may be useful to the Review.
One area we would seek to highlight is the need to adequately consider transition costs for any changes to the current model. In particular, we note that:

- A revised model would likely have high transitional costs, requiring extra levels of oversight for at least one cycle to ensure no loss to public safety. Given the variety of professional activities (and variety of training within individual professions), attention to detail is critical here;

- The principle of ownership is important: currently, optometrists are willing to work in peer-review roles for relatively low rates, because of a sense of professional collegiality. Removal of peer oversight to a central administrator is unlikely to attract the same generosity; and

- Both as a source of efficiency, and as a contribution to competitive market supply, OCANZ provides a single approach between Australia and New Zealand. It is difficult to see how these benefits would be maintained if there is not to be a single body responsible for accreditation functions in both countries.

None of this is to say that we believe there is no room for incremental reform within the current system. There are opportunities for savings, alignment between professions, and greater innovation. OCANZ is working both internally, with education providers and with other accreditation agencies on these goals, and is pleased to comment in the following pages on various opportunities for such reforms suggested by the Review.

That said, while we see merit in convergence in some areas, this should not dilute either the profession-specific oversight of optometry by optometrists of optometrists, nor risk a level of collusion which limits future competition or innovation.

Finally, we recognise the importance of transparency and independence. These are discussed in some detail below, but we accept there is merit in a further layer of oversight within the current system. Compared to radical change, we believe this could be instituted both with economic efficiency and limited risk to safety, quality or public trust.

About OCANZ
OCANZ has been accrediting programs of study in optometry in Australia and New Zealand and examining overseas trained optometrists seeking registration to practice optometry in Australia and New Zealand since 1996. In 2010, OCANZ was appointed by the Optometry Board of Australia (OBA) under the Health Practitioner Regulation National Law Act 2009 (the National Law) as the accreditation authority for optometry, and is part of the National Registration and Accreditation Scheme (NRAS). OCANZ also carries out accreditation functions for the Optometrists and Dispensing Opticians Board of New Zealand under the Health Practitioners Competence Assurance Act 2003.

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1 OCANZ currently accredits nine programs of study offered by six universities and one non-university optometry college, with an application for a new entry-level program from another university pending.
During the more than two decades in which OCANZ has been in operation, we have overseen the development and delivery of quality accreditation functions which provide assurance to the public and regulators that optometrists have the knowledge, skills and competence to practise safely in Australian and New Zealand health care settings, along with an appropriate foundation for lifelong learning.

To deliver these outcomes, we have been guided – and continue to be – by six cascading principles, in priority order:

1. OCANZ is first and foremost charged with ensuring that consumers can trust the safety and quality of training and assessment provided to those seeking registration as optometrists; and in concert that entry-level optometrists may be confident they are justified in assuring patients of that safety;

2. Setting rigorous standards and a qualification gateway which are genuinely indifferent to the pre-entry qualifications, training styles, duration or location of education: instead, we actively approve any course which will effectively prepare graduates for a common set of testable outcomes;

3. Benchmarking our accreditation standards to practical outcomes, measurable by a range of methods, including examination, peer review and requisite exposure to practice. This again embodies an indifference principle: we recognise there are different ways to evaluate capability, knowledge and safety, compared to – for example – a single national exam;

4. Working with education providers to ensure graduating optometrists have an appropriate foundation for increased scope and innovation of practice, so that we are addressing future, rather than just current workforce capability;

5. Working with other professions, to develop shared models of quality assurance and expression of standards, and to ensure graduate optometrists have the capacity to work in multidisciplinary environments; and

6. Doing all this as efficiently and cost-effectively as possible. This involves both: continuously seeking more efficient pathways and savings; while ensuring changes are incremental, to avoid the risk of compromising public safety.

The Review will be aware that actual workforce supply is not a matter for OCANZ, but a function of consumer (student) demand and educator supply, as well as a matter for complementary regulators such as the Department of Immigration. By comparison, the ‘moment’ of accreditation is a trivial barrier to entry within a typically five-year qualification pathway. By embedding principles of indifference to inputs and processes high up in our approach to regulation, we believe we permit maximum innovation and variety to allow increased student entry, and educational supply. This is where we believe accreditation agencies can most effectively assist with workforce goals.
Response to the Three Discussion Paper Topics

Improving Efficiency

The discussion paper invites comment on greater consistency and commonality in the development and application of accreditation standards and the training and readiness of assessment panels, and asks questions about the various sources of accreditation authority income.

We believe the Review process will provide for a useful and transparent comparison of different approaches to the accreditation task, and we look forward to its output.

Development of consistent, in-common accreditation standards

OCANZ is one of five Accreditation Councils\(^2\) which have consulted on common accreditation standards for entry-level programs of study. Subsequently we have fully aligned our standards for programs in ocular therapeutics with our entry level standards. During these processes, the OCANZ standards have been reduced from 10 to 5 to focus on public safety outcomes and the learning outcomes required for professional competence in optometry. The new OCANZ standards explicitly address government priorities such as interprofessional learning and ask providers how they are training optometrists to meet future heath care needs. They require entry-level programs of study in optometry to be aligned with the cross-disciplinary Threshold Learning Outcomes (TLOs) for Health, Medicine and Veterinary Science.

For OCANZ, using the Australian Dental Council (ADC) accreditation standards as the basis for our standards review has been both efficient and effective. It has reduced the cost and time required to research standards frameworks in general and has eliminated the need to separately benchmark the requirements of other Australian Accreditation Councils (as this material as well as draft standards was generously shared with us by the ADC).

This collaboration enabled OCANZ to focus its own research solely on optometric best-practice nationally and internationally. It provided a critical comparator and template for us to prepare evidence guides, to accompany common standards: indicating how standards are to be met in optometry programs of study.

This is a matter of constructing common approaches, rather than distilling common standards. The OCANZ experience is that profession-specific input, as opposed to cross-profession considerations, is paramount in relation to the interpretation of standards for a specific profession.

However, using shared frameworks is both a source of transparency for consumers and regulators, and as source of quality and safety. There are currently no systems or funding in place to drive the development of consistent/common standards frameworks across the NRAS Scheme. The collaboration on standards between Accreditation Councils is possible only because of the positive

\(^2\) The Australian Dental Council was the first to develop standards which were subsequently shared in profession- specific consultations by the Australian Physiotherapy Council, Australian Psychology Accreditation Council, Council on Chiropractic Education Australasia and OCANZ. To date, only the National Boards for Dentistry, Optometry and Physiotherapy have finalised their deliberations on the common standards, with Physiotherapy Board changing both to the structure and content of the proposed common standards.
relationships which have been developed voluntarily between members of the Health Practitioners Accreditation Councils’ Forum (HPAC Forum). A cross-profession funding mechanism would be most helpful.

On the issue of the HPAC Forum, we note that the discussion paper, while it acknowledges the purpose of the Forum, is at times critical of its rate of progress. OCANZ is of the view that this is an unreasonable criticism on two counts: firstly, profession-specific safety requirements demand a cautious and measured approach to convergence, to ensure we do not embrace risk as the price of reform and secondly, it does not give due consideration to the limited resource base of the Forum.

AHPRA has issued procedures for the development of accreditation standards which are silent on issues of content in general and commonality of standards in particular. They do not require collaboration by the developers of standards (accreditation authorities) or collective decision-making by the approvers (National Boards) on common items. There is also no mechanism in the current arrangements to conduct cross-profession consultations on common topics such as ethics or prescribing.

OCANZ is of the view that investing in a thorough revision of the AHPRA procedures document, and aligning the timing at which standards are reviewed, could address all the Review requirements for uniform structure, content and terminology: it would provide a standard framework, while permitting exceptions to maintain profession-specific safety.

This view is in line with the discussion paper’s interest in risk-based accreditation. While optometry may have reduced risk compared to ophthalmology or neurosurgery, it involves physical assessment of intervention in the eye which if misdiagnosed or mistreated can have acute health consequences, indicating risk levels which may be higher than in other health professions.

We are also concerned that a pursuit of uniformity within multidisciplinary assessment teams or even multi-profession oversight groups such as the HCPC may erode the benefits of profession-specific guidance. While this may seem counter-intuitive if the primary goal is simple efficiency, it is the interaction of profession-specific knowledge and capability which allows for identification of shared and integrated roles and systems.

Alignment with TEQSA
OCANZ will shortly sign a memorandum of understanding with TEQSA to formalise previously informal agreements to exchange information if/as required. TEQSA’s most recent comment on the OCANZ accreditation standards is that:

“‘It is pleasing to see that the proposed OCANZ accreditation standards align with the [Higher Education Standards] Framework and that a focus on outcomes has been adopted. The proposed standards appear to be in harmony with the 2015 [TEQSA] Framework and I do not foresee any difficulties in their operation alongside the 2015 Standards Framework’”

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3 See TEQSA submission published on OCANZ website at [http://ocanz.org/accreditation/standards-review?id=31](http://ocanz.org/accreditation/standards-review?id=31). TEQSA processes are, in the case of universities, focused on institutions and not programs of study. TEQSA evaluates programs offered by non-self-accrediting bodies using similar standards to OCANZ.
This endorsement of outcome-focused accreditation for optometry programs aligned with and not duplicating the Higher Education Standards Framework recognises the appropriate roles for each body. It allows OCANZ to focus on the requirements of the National Law, on profession-specific knowledge, and innovation in educational delivery within a safe practice framework.

**Cyclic accreditation and risk-based evaluation approaches**

OCANZ does not regard risk-based approaches and cyclic evaluations as mutually exclusive. In practice, both are necessary: risk-based assessment is the filter through which individual changes to standards or programs are assessed; cyclic evaluation adds a macro-approach to the overall system within which risk-based assessment is a core tool. A germane comparison here would be with the Therapeutic Goods Administration: it uses risk-based assessment to consider registration of individual devices and medicines and to monitor the compliance of providers (manufacturers/sponsors); but cyclical review to consider whether its overall settings remain appropriate.4

As noted in the Review discussion paper, OCANZ operates a cycle of accreditation and re-accreditation of up to eight years. The length of cycle aligns with that of the American Optometric Accreditation Council (AOAC) 5, which regulates the provision of accredited optometry programs in the USA and Canada, and is the appropriate comparator because they oversee the accreditation of programs of study which offer the most comparable international standard of optometric education to Australia.

We support the value of a cyclic approach, as does TEQSA because:

> “the higher education sector generally sees ‘continuous improvement’ as an integral part of academic quality assurance. Continuous improvement is typically based on an on-going reflective feedback **cycle** involving monitoring, review and consequent evidence-based improvements both of courses and of major controls on academic quality such as assessment policies and procedures.”6

A cyclic approach to the accreditation and re-accreditation of programs of study enables OCANZ to evaluate programs of study at points in time using multiple data sources including face-to-face interviews with: staff; students; graduates; external clinical supervisors; and employers; and to publish transparent reports for institutions, regulators and the public at set intervals.

OCANZ notes that TEQSA requires all accredited courses of study to be subject to periodic (at least every seven years) comprehensive reviews that are overseen by peak academic governance processes and include external referencing or other benchmarking activities. This length may be a suitable benchmark for establishing consistency of cycles across regulated health professional

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accreditation processes if that is a priority Review outcome. OCANZ is able to meet 7-year rather than 8-year cycles if required.

Critically, a long cycle review of accreditation does not restrict accredited providers from varying course content or implementing innovations during a given cycle. We encourage education providers to take advantage of technology and practice innovations, while meeting core outcomes. There is no separate fee to enact major change processes, which are in general able to be evaluated efficiently by the OCANZ Accreditation Committee at marginal cost.

OCANZ produces detailed reports of accreditation, major change and re-accreditation processes for providers and regulators and also publishes summary reports of these processes on our website. This is consistent with the international consensus that quality assurance bodies should make summary reviews and evaluation available to society at large, to engender public trust.7 The Australian Medical Council is the only other accreditation authority in the NRAS Scheme at present publishing such reports. We believe that safety and quality are incomplete goals in the absence of public awareness and associated levels of trust. This is an example of transparency which OCANZ views as critical to delivering our full mission.

Within the accreditation cycle, the OCANZ approach is risk-based and whenever possible light-touch. Annual reporting and monitoring of conditions is done by the OCANZ Accreditation Committee in the first instance: with assessment panels of reduced size formed on the recommendation of the Accreditation Committee by the OCANZ Board only if there is significant evidence of failure to meet a Standard and/or unsatisfactory progress towards addressing previously identified criteria of concern.8

Applications for major change to a program of study during an accreditation period are likewise subject to light-touch risk assessment in that they typically only require an on-paper evaluation by an assessment panel of reduced size meeting electronically. A site visit is only triggered by a change which presents a significant departure from the accreditation standards, or if the process to address change is manifestly inadequate.

OCANZ does not consider the gradual evolution of a program of study in response to initiatives to meet the expansion of optometry practice to be a major change. We believe it is appropriate flexibility within the accredited program.

Since 2010, the application of the above arrangements has resulted in only one assessment team visit to a provider during an accreditation cycle: evidence that risk-based assessment is operational at OCANZ and used only when necessary.

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OCANZ has just commenced a joint project with the Council on Chiropractic Education Australasia and the Occupational Therapy Council Ltd to develop a common risk-based framework for use within the accreditation processes of the three Councils. The project, which will be completed by August 2017, will consider and incorporate good practice already in place in other Accreditation Councils in Australia and internationally and will reflect the work of the three Australian Accreditation Committees. It will include consideration of related regulatory requirements (for example, TEQSA), the role of accreditation and professional standards, program and process risk assessments, and the harmonising of requirements: as well as examining the merits of replacing fixed review cycles with a process that tailors the intensity and frequency of external review to each provider. This latter element would have its own risk-based measure, reflecting the longevity and outcomes of individual providers.

Involvement of consumers
OCANZ regards consumer involvement in accreditation functions as essential. We recognise that students, graduates and employers are the main ‘consumers’ of programs of study, with the public the main beneficiary of good training: we involve all these groups in developing accreditation standards and when conducting accreditation processes.

We involve consumers by: having community representatives involved in decision-making about accreditation (on the OCANZ Board and OCANZ Accreditation Committee); interviewing stakeholders during site visits; publicly advertising each accreditation process inviting comment on the program/s being assessed; and writing individually to a wide range of groups including student organisations, professional bodies, health consumer and health complaints bodies, inviting comment on each accreditation process. We also review each provider’s interactions with consumers, for example through external reference groups for a program of study or the feedback mechanisms which obtain views from health consumers attending on-campus optometry clinics.

These mechanisms offer multiple points for consumer engagement at lower cost than having one consumer representative appointed to every assessment team. The incremental cost of a health consumer on every assessment team (an average cost of $6K per process) would in the OCANZ case be a charge to the education provider. It would be a substantial additional cost for no apparent benefit: we are confident that the consumer views are addressed within our standards-setting and accreditation processes.

Training, readiness and size of assessment teams
In 2009 a literature review on peer review of health practitioners/practices by the Australian Commission on Safety and Quality in Health Care found that:

- Increasing the number of peer reviewers generally increases the reliability of peer review processes, with too few reviewers potentially reducing the reliability of the outcome and too many reviewers having resource/efficiency implications;
- The use of structured assessment tools such as surveys and checklists increased the reliability of peer review between assessors; and
There is more evidence for the efficacy of tools than for training of peer reviewers to improve the reliability of peer review processes. However, there is scant literature on the exact relationship between the quality of peer review and training, and limited research into peer review in general.9

OCANZ currently uses up to four expert reviewers on its assessment teams, including an employer optometrist and an international optometric educator10 for all accreditation and re-accreditation processes. We pay assessment team members a capped rate of $2720 per assessment process (ex GST) for a three day site visit and all out-of-visit analysis and reporting tasks, which typically sums to 5 days of work. This is comparable to the TEQSA daily rate of $621 (ex GST) which would indicate a fee of $ 3105 for the allocated time. We also organise and pay for travel, accommodation and food, and reimburse incidentals in line with an OCANZ travel policy which is aligned to Australian Taxation Office recommended rates.

OCANZ provides telephone training to its assessment teams using paper-based materials, based on the structure and content of training currently provided by the Australian Pharmacy Council and the Australian Dental Council. We also supply assessment teams with common reporting templates and other tools (for example, sample questions, sample conditions) to support uniform and reliable accreditation assessments.

Assessment teams are supported by OCANZ-employed professional staff throughout the assessment process. A staff member/s expert in both optometry and accreditation attends all meetings and site visits with providers. The staff member annually observes another Accreditation Council’s site visit as a benchmarking and learning exercise. The staff member will generally prepare the team’s draft report with input from team members as required. Our Accreditation Committee examines all assessment team reports for consistency of findings and also any conditions of accreditation which are being recommended before reports are forwarded to the OCANZ Board for approval. These processes all contribute to a common standard of assessment across programs and providers.

OCANZ is happy to support common training for and some common membership of assessment teams to enhance cross-professional collaboration but notes that the limited available literature does not support this as necessarily the best investment to ensure efficiency and consistency. Our view is that consistency and public safety are best assured in the various ways described above, predominantly by using sufficient numbers of peer-review experts in optometry. Their use reflects our continuing emphasis on quality and trust.

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10 An international assessment team member is used on all OCANZ panels. As noted in the following Canadian study citation, the use of international reviewers enables [OCANZ] “to minimize reviewer demand [domestically], decrease possibilities of conflicts of interest and positive or negative bias, and to support the capacity of programs to “excel, according to internationally accepted standards...” See http://www.cihr-irsc.gc.ca/e/documents/peer_review_international-report-en.pdf
OCANZ efficiency, sources of accreditation authority income, education provider fees

Whether or not the OCANZ expenditure to address the goals of the National Law is efficient or cost-effective is a complex question. Following the principles outlined above, combined with risk-based assessment approaches, we are confident that we provide a balance between safety and flexibility. To rebalance this, we would need to consider ‘how much’ we might reduce the safety, quality and trust emphases for potentially marginal savings.

While we do not doubt that there are incremental efficiencies to be gained, and have examples of OCANZ making such efficiencies, we believe they are exactly that: incremental. Given the demonstrated success of current accreditation in assuring safety across the regulated health professions, it is not clear that there is a case for other than cautious reform. While rare examples of poor practice may occur in any profession, these tend to argue for a greater emphasis on safety, not its compromise.

As noted above, we have not undertaken a full cost benefit analysis, and we note that any such activity will be highly sensitive to its priorities and assumptions. Equally, we are limited by the absence of a strong comparator: the Accreditation Liaison Group has already commented at length on the deficiencies of international comparisons undertaken by the previous NRAS Review, and we endorse this view.

There are six comments we would make in relation to what we perceive as efficiency markers for OCANZ. These are:

1. To the extent that benchmarking and comparison are useful, we are assiduous in matching our rates to recommendations of TEQSA and the ATO (see above) and periodically look at international costs to identify whether there are significant departures from modal costs (see US commentary later);

2. Operating across multiple markets (Australia, NZ, and international graduates) gives us a strong sense of market comfort or resistance to our pricing. In particular, the direct comparison for educational accreditation in Trans-Tasman markets suggests that our fees are reasonable despite radically different health-finance arrangements;

3. As noted above, we believe there are significant savings derived from the maintenance of peer accreditation, with no evidence that this leads to any entry restrictions for the optometry profession. In particular, on this point, we note that complementing the willingness of optometrists to participate on accreditation panels at the TEQSA rate, members of the profession provide their skills to OCANZ governance and accreditation activities at a range of rates ranging from zero to a range of heavily-discounted rates. Our assessment of the value of this unpaid or discounted support is that it delivers a net annual value of $183,800, reflecting on average a 75% discount from market rates\(^{11}\). This is a productivity measure associated with a ‘sense of ownership’, and which we would expect to be lost as any accreditation model gains greater distance from the profession;

\(^{11}\) This is against an assumed median daily standard remuneration expectation of $1200. OCANZ would be pleased to provide more detail on this calculation as required.
4. Overall, looking at the datasets within the Costings Working Group paper, the total income of OCANZ does not appear to be at odds with the risk levels and small number of programs of study and education providers that we oversee;

5. To undertake a more detailed direct comparison between two professions of similar scale, OCANZ has recently exchanged data with the Australian and New Zealand Podiatry Accreditation Council (ANZPAC), which also accredits its profession trans-Tasman. Key outputs from this 2015-2016 data comparison are:
   a. We service similar-sized professions in Australia, with 5142 optometrists at last count, compared to 4665 podiatrists;
   b. Annual Board fees and expenses are comparable for both bodies\(^{12}\);
   c. We have different models for accreditation charging:
      i. OCANZ charges providers annually, at $12,300 per annum for accreditation over an eight-year cycle;
      ii. ANZPAC charges fees per process -$30,000 for an initial accreditation for a five-year cycle, with a $5-10,000 fee for each follow-up during the cycle;
      iii. The annual fees from education providers are $68,000 for OCANZ from 7 providers and $67,000 for ANZPAC from 11 providers;
   d. OCANZ spends 31% of its total budget on the direct costs of accreditation including staff and committee oversight; ANZPAC spends 20% of its budget on accreditation excluding staff and committee costs;
   e. Sources of funding are different, with:
      i. OCANZ attracting 45% from the OBA, 10% from education providers, and 45% from other sources, including overseas trained professionals and the NZ regulator;
      ii. ANZPAC’s split being 53/25/22% respectively;
   f. The scope of activity of the two bodies varies significantly, most notably with respect to the requirements for and costs of examining overseas trained professionals despite the fact that both are skilled migration agents. OCANZ also regulates a profession twice the size of podiatry in NZ, and has a role in auditing continuing professional development;

Within these data, we see substantial disparity between income, expenditure and allocation of activity. This is a consequence of profession-specific requirements and risks, as well as regional differences, which would not be captured in a uniform model; and

6. Any cost benefit analysis might also reasonably consider the broader systemic savings delivered by optometrists. To the extent that there is substitutability within our professional services, we might consider the counterfactual case that there were no optometrists, and the profession’s work was done either by ophthalmologists or GPs. If we consider as a measure that 75% of eye interactions are undertaken by optometrists in Australia each year, and consider only an initial consultation:

\(^{12}\) Board member fees are at $31,000 for OCANZ and $33,000 for ANZPAC.
a. Under MBS Item Number 10910, a comprehensive initial consultation by an optometrist of over 15 minutes has a benefit of $56.80, and the benefit is limited to every three years for patients under 65 and annually for patients over 65;

b. If the initial consultation were provided by a general practitioner, then it would typically be a Level C attendance of 20-40 minutes, attracting a fee of $71.70;

c. Given the limitations of general practice – both skillset and optical technology – this would then typically require access to the ophthalmology schedule, which further increases cost;

The point of these observations is to note that there are significant efficiencies and savings associated with the safe delivery of qualified optometrists which are captured across the continuum of workforce capacity, and to which accreditation contributes.

We would also note that our pursuit of maximum indifference to forms of educational innovation and flexibility, while maintaining the safety focus, suggests strong productivity against reasonable cost.

With respect to the different sources of income, we would emphasise the substantial reliance of OCANZ on sources other than the OBA and educational providers. This reflects a deliberate attempt to gear our income to market demand.

OCANZ agrees with the HPAC Forum that, in accordance with Principle (3) (b) of the National Law, fees charged should remain reasonable, having regard to the efficient and effective functioning of the Scheme. We consider that to achieve this all users should contribute to the Scheme, that is: registrants; education providers; and, recognising the public benefit of safe and competent health practitioners, governments.

In the absence of a uniform policy across the NRAS Scheme, the OCANZ Board’s current policy is to set fees at a level which recoups: the direct costs of accreditation assessments (assessors’ fees, travel, accommodation etc.), the cost of all staff performing accreditation assessment functions, and all committee costs associated with considering/approving accreditation process reports. OCANZ annually compares our fees with those Accreditation Councils which levy an annual fee on providers.

We also periodically benchmark our accreditation assessment costs with other providers willing to share information. In 2015 this led to the introduction of various internal efficiencies which did not threaten quality: for example increasing the preparation work pre-site visit to reduce visit length. To maximise transparency, we reference such facts in our annual funding bids to the OBA: our approach to charging is also advised annually to education providers.

With respect to establishing fees charged to overseas trained optometrists, OCANZ has a similar policy to the above i.e. we recover all direct costs, staff costs, and the cost of Committee oversight of the examination. We annually compare costs to other accreditation bodies that offer similarly structured exams (to the extent possible given profession-specific differences).
Relevance and Responsiveness

Outcome-based accreditation standards
As already stated, OCANZ has adopted outcome-based accreditation standards which do not specify how learning outcomes are to be achieved in optometry, and we were not particularly prescriptive about inputs or processes in its previous standards. This has led to the following examples of flexible design within the accredited optometry programs of study in Australia:

- Entry-level programs at different levels of qualification (double bachelors; bachelor/masters combinations; professional Masters’ level Doctor of Optometry);
- Programs designed for entry both by school leavers and first degree holders;
- Course length has varied to meet specific learning objectives (courses range from 3.5 to 5 years in length, dependent in part on prior qualifications for entry and whether programs are being taught over 2 or 3 semesters per annum);
- Wide variation in the way in which clinical training is delivered to ensure work readiness. The historic way of training optometry students in Australia was predominantly at on-campus clinics offering limited interaction with other health professionals. Clinical practice now involves training at on-campus clinics (not all providers); placement in optometry practices; experience in hospitals and in private practice working with other health practitioners particularly ophthalmologists; and possibly also overseas placement. There are multiple opportunities to interact with other health professionals during training (see later comments on IPE); and
- Variable curriculum structures/methods of teaching, including the volume of simulation.

This diversity of arrangements described above and later under this heading demonstrates that OCANZ does not have a rigid approach to accreditation, and permits innovation consistent with the various objectives of the National Scheme and local community needs/priorities. OCANZ has actively worked with education providers and prospective providers using risk-based accreditation approaches to permit variety of program design, particularly where it captures local opportunities. We believe permitting heterogeneous pathways each ending in a common and safe professional capability is a mark of our success: innovation is already occurring rather than yet to be achieved.

While the OCANZ focus is on program outcomes, a complete separation of process/structure and outcome in education program design would be artificial. It would risk failing to provide for in-depth integrated program development and would not reliably deliver programs readily measurable by accreditation teams, especially in the case of new programs where there are initially no outcomes to measure. The danger of focussing overly/solely on process is that it may lead to graduates who resemble properly-trained optometrists, but whose competence in an outcome-based accreditation model has not been proven.

OCANZ has accredited two new optometry programs in Australia in the last 5-6 years which are only now producing their first graduates, and we have further queries about new programs in train. We believe that an outcome-based approach to health professional education compared to a process/content orientation is not an ‘either or’ proposition. Australian healthcare consumers are reaping substantial benefits from the current model – not least safety – which brings into question why the costs and risks of any radical transition could be considered.
Responsibility for professional competency frameworks

In optometry in Australia - as for pharmacy - the development of professional competency frameworks has always been a matter for the professional body. Optometry Australia, formerly the Optometry Association of Australia, commenced this work for the optometry profession in 1993 and has just completed its fifth revision of the entry-level competency standards for optometry using a robust process which includes extensive consultation, peer review and publication of both its process and outcomes in a peer-reviewed optometry journal13.

Since 2005, the Global Competency-Based Model of Scope of Practice in Optometry has been adopted by the World Council of Optometry, based on the entry-level competency standards developed by Optometry Australia. The model is helping to address the challenges of increased practitioner mobility across international borders and promote greater harmonisation of optometric education around the world.14

Internationally in optometry, there is no single arrangement in place for the development of professional competencies, with the regulator specifying the scope of practice for optometry in New Zealand, and in the UK both the regulator and the professional body articulating some of the requirements for optometric professional practice. In the USA, individual optometry programs may self-determine the professional competencies required of their graduates15. The Association of Schools and Colleges of Optometry in the USA also publishes guidance on the competencies expected of entry level graduates.16 In Canada, the Canadian Examiners in Optometry have developed their own list of the competencies required of optometrists for safe, effective and ethical practice at point of entry to the profession in Canada, primarily to inform the content of their national examination but also for the reference of education providers and the profession.17

OCANZ currently has the option whether or not to recommend to the OBA that its accreditation standards are based on the professional competency frameworks developed by Optometry Australia. It is also optional for OCANZ to add/delete requirements. To this end, we have recently proposed to the OBA in the therapeutics course standards that the administration of oral therapeutics be taught in all OCANZ accredited courses (the profession in Australia currently only has a scope of practice to prescribe topical therapeutic agents), with a view to preparing entry-level optometrists in Australia for a potential widened future scope of practice.

OCANZ can see the merits of introducing a policy to guide consistency in the process of developing professional competency frameworks to be used for accreditation purposes in the regulated health professions. We note that such a policy would be a useful framework for increased transparency, and could improve the efficiency by which professional competencies in common to multiple health

13 See https://www.ncbi.nlm.nih.gov/pubmed/25545949
14 See http://www.worldoptometry.org/
15 See for example, Indiana University School of Optometry Professional Optometry Degree Program Entry-Level Standards at http://www.opt.indiana.edu/intranet/repository/clinic/entry_level_standards.pdf
professions are developed. In this latter area, we note the capacity for a set of common competencies to be developed in areas such as communication, ethics, cultural competence, and evidence-based practice.

However, we see no strong argument for changed authorship of the core professional competencies for optometry or for authorship to necessarily be identical across professions noting that the task is largely a profession-specific activity. The current costs to NRAS would increase if Optometry Australia, which currently meets the total cost of developing the optometry’s professional competency framework (because the profession is the owner of this work), would in future justifiably seek to be funded by NRAS if subject to externally-imposed requirements.

Assessment and the question of national examinations
The OCANZ accreditation standards have recently included the requirement that external experts assess students’ competence in final year, without specifying how that will take place. This arrangement is consistent with outcomes standards that do not specify how learning outcomes are to be achieved.

It requires optometry providers to demonstrate that they are benchmarking students’ competency to practice at entry level to the profession in their final year, and holds the provider to a clear standard in relation to learning outcomes (the achievement of competency to enter practice). However, it accommodates a range of assessment methods to demonstrate competence which may include portfolio assessments and/or set final examinations. OCANZ considers that valid and reliable assessment methods are best evaluated within the overall context of assessment in the specific program of study. This is alignment to the risk-levels of particular professions, rather than alignment to an abstract uniform standard.

OCANZ is not persuaded that national examinations are a useful way to determine the educational quality of programs of study. 18 National exams tend to skew aspects of educational design to meet the exam requirements, rather than to develop overall outcome-based competency throughout the full duration of programs of study. The OCANZ experience supports the findings of this recent study in osteopathy that:

“The literature confirms that the context-specific nature of clinical reasoning requires multiple assessments in different contexts by different assessors to optimize the validity and reliability of the overall assessment.”19

We would be deeply concerned that this would undermine the innovation outcomes described above. This illustrates a further tension inherent in the Review’s Terms of Reference: what is

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simpler, more efficient and centralised may in practice be much less effective in addressing workforce goals.

We also do not see it as efficient to impose the additional cost of national examinations on students, who would likely bear the total cost. As neither the USA nor Canadian optometric examining bodies publish financial information, the costs of developing and implementing such an examination are not able to be estimated in this submission.

In terms of ongoing cost, we know that Canada, which has a similar number of optometrists practising domestically as in Australia (≈4,600 to ≈5,000) and examines a similar number of Canadian/USA candidates each year as the number of optometry graduates produced annually in Australia (currently about 250) charges $5.8K AUD per person for its national examination. A similar standard of examination would therefore add an estimated $1.45 million AUD annually to the cost of accreditation functions for the optometry profession in Australia.

There is no evidence from the separate optometric accrediting body for the USA and Canada - the Accreditation Council on Optometric Education (ACOE) - that national examinations have reduced the level of scrutiny that is applied when programs of study in optometry are accredited, or reduced the fees paid by education providers. By way of comparison, an annual fee of $7,600AUD is charged by the ACOE, which excludes the considerable cost of assessment panel site visits, compared to an annual fee of $12,300AUD charged by OCANZ and inclusive of these costs.

**Interprofessional education, learning and practice**

OCANZ is a signatory to the 2015 HPAC Forum position statement on interprofessional learning. The OCANZ accreditation standards include a requirement that principles of inter-professional learning and practice are embedded in the program of study. We neither limit consideration of cross-professional opportunities nor inhibit workforce innovation. This requirement has supported direct improvements in optometry programs, with one provider recently reporting that in response to the OCANZ accreditation standards, “we have implemented [new] formal inter-professional education (IPE) [requirements] into our program”.

Interprofessional collaboration between optometrists and ophthalmologists in learning and teaching has been a part of the optometry landscape for several decades, with all optometry schools accredited by OCANZ providing clinical training opportunities for students to observe and develop close working relationships with local ophthalmologists. For example, the University of Melbourne hosts a weekly satellite clinic of the Ophthalmology Department of the Royal Melbourne Hospital at its university-based optometry clinic. Here students, under the guidance of two staff optometrists, work up and propose the treatment of general public outpatients to the supervising ophthalmologist, who confirms the management plan and debriefs the students. The University clinic now also employs an occupational health physician working with students on colour vision issues in certain occupations.

At QUT, first year units suitable for optometry students are taken by students from a wide range of disciplines – optometry, pharmacy, nursing, podiatry, paramedicine, nutrition and dietetics, medical radiation technology and biomedical sciences. At a clinical teaching level, optometry students...
participate in a range of clinical extension activities in conjunction with other health disciplines, through health screening and health promotion activities both on and off campus, thus promoting a multi-disciplinary approach to health care, aligning with current practice trends and the direction of both State and Federal Governments for future health care in Australia.

Cross-professional clinical care of patients is particularly reinforced within the QUT on-campus optometry clinic, where in the vision rehabilitation clinic a multidisciplinary model has been in place since 1993. It now involves social work students and supervisors jointly with optometry students and supervisors, with occupational therapy students to be involved from 2017, supervised by the OT within this clinic. Educational development psychology students together with optometry students evaluate children with learning problems in the paediatric optometry/binocular vision clinic.

These innovations are both about foundations for increased future scope for optometry and other professions, as well as developing the capacity for all participants to work in multi-disciplinary teams. The localised nature of individual program’s approaches is a good illustration of OCANZ’s light-touch approach to fulfilment of the accreditation standards.

**Clinical experience and student placements**

As stated earlier, OCANZ accredits a wide variety of clinical placement options for students designed to respond to local workforce priorities. For example, UNSW runs a public-facing clinic which services more than 4,000 patients per year and conducts in excess of 6,000 consultations. UNSW students will gain approximately 50% of their clinical experience here over the final 2 years of their degree. In contrast, Deakin University in Geelong does not maintain a public-facing clinic and exclusively places students in optometry practices for their practicum, with all students required to undertake regional/rural placement for either three or six months.

Optometry students are regularly placed in settings which respond to the special needs of particular health populations and which enable cross professional collaboration in patient care, for example:

- Students from UNSW examine patients in various community health settings. They deliver eye care services to Aboriginal Australians at the Aboriginal Medical Services centre in Redfern; to disadvantaged children at Stewart House in Curl Curl; and to diabetics at the Prince of Wales Diabetes Centre (collaboration with ophthalmologists, ophthalmic nurses, endocrinologists, diabetes case managers). UNSW students also interact with pharmacists and general practitioners through the provision of emergency eye care at the UNSW Red Eye Clinic;
- Students from Deakin University, UNSW and the University of Melbourne attend Vision Australia and/or Guide Dogs where they have exposure to optometrists working with orthoptists, occupational therapists and social workers to assist low vision patients. At Flinders University, students undertake a similar placement with the Royal Institute for the Blind;
- University of Melbourne students all see patients at community health settings including Broadmeadows Health Service (exposure to GPs, dentists, dietitians, podiatrists, physiotherapists, psychologists) and East Preston Community Health (exposure to GPs, dentists, podiatrists and physiotherapists);
• QUT students participate in various indigenous health activities including: vision screenings for primary and secondary school students; community health Indigenous well persons’ health day; nursing home visits; Indigenous outreach clinics at the Gympie/Caloundra hospital; and outreach programs to the Northern Territory and Central Western Australia through the Brian Holden Institute; and,

• All students from Deakin, University of Melbourne, UNSW and some students from Flinders University undertake clinical placement at the Australian College of Optometry, whose charter involves the provision of eye care to pensioners and Health Care Card holders.

Students also gain insights into heterogeneous geographic, socio-economic, cultural and disability-related demand for optometry through case studies.

**Simulation**

In 2011 a consultancy project for the now defunct Health Workforce Australia evaluated the use of simulation in entry level optometry programs in Australia, reporting that the use of Simulated Learning Environments (SLE) in optometry training in subjects related to clinical skill development was substantial.\(^{20}\) The report noted that most clinical methods in optometry are low-risk and able to be taught via human (volunteer, peer or patient) contact from an early stage of skill development, with higher risk procedures such as foreign body removal using animal cadaver simulation (an excised bovine eye) or manikin (an artificial eye).

The report found that SLE usage was mostly confined to low-technology options for reasons of: cost; the available time and expertise required for academic staff to develop SLE models; risk management issues; and the availability of direct and relevant patient-based contact experience. Using SLE was seen as critical in cases where there is limited access to patients with ocular pathology conditions that do not present regularly in practice. However, low-technology methods could adequately meet the required training needs. UNSW and QUT were involved in the development of, and still use the high-technology virtual refractor for training students in how to determine prescriptions for corrective lenses prior to their introduction to patient clinics. In the pre-clinical setting, students at most of the Australian universities teaching optometry now use the high technology Eyesi Virtual Binocular Indirect Ophthalmoscopes to examine the health of the posterior of the eye.

**Producing the Future Health Workforce/Governance**

Health workforce reform priorities and cross professional competencies/collaborative care in optometry

Optometry is an integral part of the primary health sector in Australia, with optometrists providing around 75 per cent of all primary eye care in Australia\(^{21}\). About half (52%) of the Australian population have eyesight problems, including long and short-sightedness (26% and 23%), as a long-

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\(^{20}\) See report by consulting provider QUT to HWA, *Use of Simulated Learning Environments (SLE) in Undergraduate Optometry Training*, September 30\(^{th}\), 2011. Copy available through OCANZ on request.

term medical condition.22 The number of Australians with low vision or blindness is predicted to double from 431,100 in 2000 to almost 800,000 in 202423, with the estimated cost of this loss in 2009 as high as $16.6 billion or $28,917 per person including loss of wellbeing.24

Optometrists not only examine eyes, and prescribe glasses or contact lenses to correct errors of refraction, but play a vital role in diagnosing and managing eye diseases such as glaucoma, macular degeneration, and diabetic retinopathy. Optometrists also perform an important role in the detection and monitoring of ocular conditions associated with systemic diseases such as hypertension and diabetes. Demand for these conditions, as well as comorbidities associated with poor vision will only continue to grow with an ageing population.

The optometry profession has direct access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS) and is able to refer to medical specialists in ophthalmology. Optometrists with therapeutic qualifications and endorsement are able to prescribe certain topical ophthalmic medications in every State and Territory (though not similar oral medications).

Various studies confirm the benefit to consumers and the health economy of more widespread use of optometrists for diagnosis and referral. 25 This includes not only optometry-ophthalmology referral pathways but also among optometrists and between eye care professionals and rehabilitation professionals and support services.26

The Review paper notes numerous requests from stakeholders for governments to articulate a clear workforce reform agenda and to communicate this agenda within the Scheme. OCANZ welcomes the opportunity to implement those clearly articulated health workforce reform priorities that are able to be addressed through accreditation processes, as in the below examples.

**Optometry is already responsive to health workforce requirements**

In response to the increasing prevalence of eye diseases in the community - particularly glaucoma - and the maldistribution of the ophthalmologist workforce (Health Workforce Australia 2012), the education and training of optometrists to enable practice at the top of their profession has been rolled out since the commencement of the Scheme, qualifying Australian graduates for registration endorsement for scheduled medicines for the management of eye conditions. From 2014, the OCANZ entry-level registration standard for all new registrants in Australia has required therapeutics training and the ability to prescribe Schedule 4 Medicines. In contrast, the UK has no such

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22 See self-reported data on the prevalence of vision loss available through the Australian Bureau of Statistics (ABS) National Health Survey 2007-08.
25 See for example, Ly A, Nivison-Smith L, Hennessy M & Kalloniatis M. Collaborative care of non-urgent macular disease: a study of inter-optometric referrals. Ophthalmic Physiol Opt 2016, 36: 632–642. DOI: 10.1111/opo.12322. This study found that intermediate-tier optometric eye-care referral pathways in macular disease has the potential to reduce non-specific diagnoses, increase diagnoses of normal aging/no apparent disease and in most cases did not require face-to-face consultation with an ophthalmologist.
requirement, with only a very small minority of optometrists qualified through post-entry-level training as independent prescribers (for example, in 2014-2015 the General Optical Council reported 11,305 optometrists registered in England but only 169 optometrist independent prescribers).

All entry-level optometry courses accredited by OCANZ have been subject to a review process to ensure that they are able to produce therapeutically-qualified optometrists. Some new post-entry-level programs have been accredited to assist with upskilling the existing workforce, and changes made to the processes for assessing the competence of overseas trained optometrists against the new requirements. OCANZ has recently added training in oral therapeutics as a requirement of therapeutics programs.

Multi-professional approaches
Working through the HPAC Forum, OCANZ has collaborated on joint initiatives such as the development of common prescribing standards for non-medical professionals and the adoption of a common position statement on interprofessional learning in support of the improved training of optometrists to deliver collaborative care.

OCANZ welcomes the introduction of a mechanism for resolving cross-profession issues that cannot be resolved by National Boards. However, as noted by the HPAC Forum previously, there is no mechanism within the Scheme for funding of multi-profession projects. Formally incorporating multi-profession work in the roles of both the Accreditation Authorities and the National Boards, backed by an appropriate funding allocation, would assist in streamlining and finding efficiencies and deliver more in relation to multi-profession approaches.

We note further that an increase in cross-professional collaboration and multidisciplinary approaches to care will be critical in addressing problems such as maldistribution in the health professions both geographically, and by socio-economic cohort, and the difficulty of attracting a range of practitioners to aged care. As noted in the discussion paper, Australia may need to take advantage of discipline overlap, and explore cross-professional collaboration and multidisciplinary approaches to care, in order to address future health care needs. OCANZ believes that the required solutions will best be addressed by a new independent oversight group, separate from the interests of AHPRA and the National Boards and accreditation agencies.

Supply/demand of optometrists as a workforce reform issue
National competition policy requires that accreditation processes attend to program quality but be agnostic on the question of the supply of health professionals. In response to this, OCANZ procedures state that when a new optometry program is being planned OCANZ will not:

Comment on the desirability or otherwise of a new optometry program except to the extent that it has a legitimate concern for the overall standards of optometric education; and,
Evaluate the workforce implications of any proposal for a new program or school. 27

These principles are consistent with the view that education providers are market-facing and make their own program investment decisions.

Health workforce supply predominantly responds to willingness to pay, from both government and private sources; the only limiting factor in an accreditation system which is outcomes-focused is the availability of opportunities for clinical training sufficient to ensure public safety.

According to the latest National Health Workforce Dataset for optometry\(^{28}\), in 2015 there were 3.0 new registrants for every optometrist that did not renew their registration from 2014. This data suggests that the optometry workforce is not undersupplied\(^{29}\) and that accreditation is not a barrier to supply although maldistribution and equitable access are ongoing issues in optometry as in several health professions. These are policy problems outside OCANZ’s ambit, however supply and demand considerations should be a priority issue for government in a workforce reform agenda given that it bears a significant portion of the cost of training.

Independence of accreditation and registration, governance and accountability of accreditation authorities

OCANZ agrees with principles which have been previously articulated by the HPAC Forum and the World Health Organization/World Federation of Medical Education Guidelines for Accreditation of Basic Medical Education (2005) that “The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession”.\(^{30}\) From the top-down, this includes independence of decision-making from AHPRA and the National Boards; and from the bottom-up, independence from education providers, students, employers, the profession, and health consumers.

OCANZ is a company limited by guarantee which, since the inception of the National Law, has had objects consistent with and limited to the delivery of accreditation functions in Australia and New Zealand. OCANZ is ‘owned’ by five Members, one each nominated by the following sponsors: the national regulator in Australia and in New Zealand, the professional body in Australia and in New Zealand, and the accredited schools nominee. The Members appoint Directors to manage the Company’s business after a public advertising process and on the advice of a Nominations Committee, and are otherwise responsible for the constitution, receipt of the annual reports and the annual appointment of the auditor.

OCANZ business is managed by a Board of Directors comprising between 8-10 persons. The current policy is to have the Board comprise 1/3 optometric educators, 1/3 practising optometrists and 1/3 non-optometrists; and to include 2-3 Directors from New Zealand. Decisions are predominantly made by consensus. Should a vote ever be required, the composition of both the Members and Board described above mitigates against agenda capture by any stakeholder group. We believe this


\(^{29}\) Indeed, the current debates relate to an oversupply of graduates, see for example: [http://www.optometry.org.au/media/516334/position_statement_the_optometry_workforce.pdf](http://www.optometry.org.au/media/516334/position_statement_the_optometry_workforce.pdf)

arrangement, plus the consumer roles discussed above meet requirements for internal independence from sectional interests. Additionally, we would note what we see as the four other critical roles within this model:

1. Centralised oversight, to ensure overall standards and adherence to the National Law, manage budgets and inform high-level policy, including workforce. This is the role met by AHPRA;

2. Expert oversight of individual professions, and contracting with accreditation agencies, independent of accreditation decisions. These are the National Boards;

3. Membership-based professional associations, who are related to the accreditation process, and provide a set of expectations, as well as authorship of key materials, but do not directly influence accreditation; and,

4. Separately from AHPRA, a centralised transparency and accountability committee which can oversee and promote interprofessional cooperation between the various agencies and other participants. This is a missing component in the current system. It is a role which would naturally be independent of AHPRA, as it would deliver disinterested commentary on the overall efficiency of the model.

OCANZ notes that the discussion paper refers to the 2005 Productivity Commission Review which recommended amalgamation of accreditation functions within a single national health accreditation agency to optimise efficiency, improve workforce flexibility and course accreditation consistency, and enhance cross-profession education and training. This was rejected at the time for a range of reasons, not least of which were the type of transitional risks, costs and potential losses outlined above.

The discussion paper also references the multi-profession regulator Health and Care Professions Council (HCPC) in the UK, which carries out both regulation and accreditation functions for a range of health professions which are unregulated in Australia plus the Australian regulated health professions of occupational therapy, podiatry, physiotherapy and psychology.

The paper notes that the HCPC does not have coverage over most of the health professions governed by the NRAS Scheme: including optometry; which together with chiropractic, dentistry, medicine, nursing, osteopathy and pharmacy in the UK are subject to profession specific regulation but oversight by the Professional Standards Authority. In practice HCPC is a not a regulator of high-risk professions.

With the exception of various incremental improvements identified in this paper, OCANZ does not consider that there is evidence that fundamental reform of accreditation systems governance is: required; cost effective; or will necessarily deliver a more sustainable health system in the public interest than the current arrangements. There is no credible basis to suggest that it would either maintain safety or increase supply. It is a proposal fraught with risk, in a highly-sensitive sector.
In particular, OCANZ notes that the HCPC is focussed on the regulation of minimum standards rather than innovation or workforce reform, and that social work currently being removed from the HCPC remit by the UK government to a ‘specialist’ regulator for social work combining regulation and improvement functions because a multi-professional model is “unable to focus on driving-up standards in social work, focus enough attention on standards in qualifying social work education, and because social work lacks a professional college to lead on improvement”. 31

OCANZ sees that similar risks for optometry would arise from a move to a single agency, including a reduction in the availability of unpaid support from the profession to set and maintain accreditation functions.

OCANZ recognises that transparency and accountability of accreditation in the national scheme could be enhanced by improving the contracting arrangements with accreditation authorities and the associated reporting requirements. We have no objection to the establishment of an independent governance committee separate from AHPRA which could oversee and report on macro-level accreditation decisions separate from the contract relationship between the Boards and the accreditation authorities. As described above, this committee could also take a lead role in unleashing the benefits available from leveraging overlap between professions.

**Trans-Tasman benefits**

In addition to the direct benefits attained through the accreditation functions exercised in Australia, there are indirect benefits from activities conducted by OCANZ outside Australia. Under the Trans-Tasman Mutual Recognition (TTMR) arrangement any person registered in Australia to practise an occupation is entitled to practise an equivalent occupation in New Zealand, and vice versa, without the need for further testing or examination3. OCANZ carries out both the accreditation of programs and overseas assessment functions on behalf of the New Zealand optometry regulator, applying the same accreditation standards and processes across Australia and New Zealand.

This consistency in accreditation functions between the two countries assures trust in the competency of health practitioners when the TTMR arrangements are applied. While the costs of accreditation outside Australia are not borne by the entities or individuals within Australia, the value in protecting the Australian public with this common assignment of function is an efficiency which any proposed changes to the scheme should continue to preserve.

These benefits would inevitably be undermined by a unilateral change in the Australian NRAS from profession-based to centralised regulation.

**Assessment of overseas trained optometrists**

The assessment processes for overseas trained optometrists, for Australian registration and skilled migration are both carried out by OCANZ and are aligned within a single program (with the exception of a modified process for skilled migration purposes to verify the education and

31 Quoted by HCPC presentation by Anna van der Gaag, Former Chair; Michael Guthrie, Director of Policy and Standards to Health Professions Accreditation Councils’ Forum, Melbourne, 23 September 2016
registration standing of international students who have studied optometry in Australia or New Zealand).

From 2013-2016 OCANZ has examined 40-80 overseas trained optometrists per annum, trained in the diverse education systems of Austria, Canada, Hong Kong, Ghana, India, Iran, Ireland, Israel, Malaysia, Nigeria, Philippines, Singapore, Spain, South Africa, the UK and USA. The majority of examination candidates trained in the UK, but these candidates have variable years of practice subsequent to registration and variable recency of practice which impacts on examination outcomes.\textsuperscript{32} As one example, in our current round of written examinations candidates’ prior study from the same UK provider was completed as early as 1985 and as recently as 2016, a span of over 30 years.

OCANZ tests all overseas trained candidates in the same way, using both written and clinical examinations. The examinations were recently found by an expert independent reviewer to be “with some exceptions largely surrounding process issues, ...consistent with international best practice for such examinations and is constituted and delivered in a highly professional manner by dedicated and diligent staff working mostly to effective protocols”\textsuperscript{33}. We are currently correcting the small deficiencies in our protocols and making the enhancements recommended by the independent reviewer.

OCANZ reports annually to the OBA and publicly on both candidate numbers and examination success rates, and similar to other accreditation council has outcomes that see just under 50 percent of candidates typically passing the OCANZ examination on first attempt. This includes candidates from Canada and the USA who undertake the courses most comparable to those taught in Australia and New Zealand.

OCANZ is of the view that assessment pathways and approaches to the assessment of overseas-trained health professionals should protect public safety and be equivalent to domestic outcome-based assessments. In the case of optometry, the scope of practice of an optometrist and related education requirements differ significantly from country to country which argues against a competent authority pathway being a safe way to enter the profession in Australia or New Zealand.

We note in this context that there are sometimes proposals for foreign competent authorities to accredit students for practice in Australia. We believe this would be inconsistent with the expectations of Australian consumers, and antithetical to our view that regardless of training source, Australians should expect a single approach to their safety and healthcare quality.

\textsuperscript{32} Refer OCANZ annual reports available at \url{http://ocanz.org/} for examination statistics
\textsuperscript{33} See Report to the Optometry Council of Australia and New Zealand on the Review of the Assessment of International Graduates by Professor Brian Jolly, University of Newcastle, February 2016, available from OCANZ on request.
The OCANZ view is that a common competent authority pathway for optometry is neither feasible nor desirable because:

- Public safety is at risk if a competent authority pathway were to be established without the adoption of detailed best practice evaluation processes profession by profession;

- Evidence suggests that a competent authority pathway would need to evaluate both qualifications and subsequent experience to ensure safety, but the impact of experience on safety is unclear as is how to establish sound criteria to evaluate it;

- In many jurisdictions, competent authorities are private providers, with an interest in approving candidates. This is well-evidenced in areas such as pharmaceuticals and medical devices; and

- In the case of optometry, the small numbers of overseas trained optometrists involved and the wide range of countries involved contends against the development of a quality competent authority pathway as a cost effective proposition.

This would also be a departure from the current Trans-Tasman model, which would have consequences for our open workforce arrangements.

The current process of individually examining overseas trained optometrists against the Australian and New Zealand competency standards for entry-level optometry practice is working well to assure public safety. In the absence of workforce shortages, and with no pattern of consistent results for applicants from any country undertaking the OCANZ examinations, the evidence does not support change.