From the President

1 May 2017

Professor Michael Woods
Independent Reviewer
Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professions

Via Email: admin@asreview.org.au

Dear Professor Woods

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

Thank you for the opportunity to provide input to your Review of Australia’s National Registration and Accreditation Scheme (NRAS) for health professions, as commissioned by the Australian Health Ministers’ Advisory Council.

**Introduction and summary**

The Royal Australasian College of Physicians (RACP) is accredited to provide postgraduate education and training for medical specialists across 8 specialties and 34 fields of specialty practice.

The RACP also provides continuing professional development programs and resources to its membership on topics as diverse and wide-ranging as Indigenous cultural competency, countering cognitive bias, migrant health, or new diagnostic technologies. Our membership covers over 16,000 physicians and over 8,000 trainees in Australia and New Zealand.

As the Australian Medical Council’s (AMC) most recent Accreditation Report notes, ‘[t]he RACP is the largest specialist medical education provider accredited by the AMC, in terms of number of trainees, discrete training programs and the number of fields of specialty practice and number of specialties covered.’ The RACP’s current accreditation lasts until March 2021.

The RACP is supportive of the Review’s aim of identifying potential improvements to the NRAS to ensure its optimal efficiency and effectiveness. Whilst the system works well overall, continuous assessment and improvement should always be an integral aspect to such an important system that underpins the quality and safety of Australian’s health
system. In the main, our views about the current Review are consistent with our submission to the 2014 review conducted by Mr Kim Snowball, which is enclosed for your information.

In summary, whilst we recognise that there are challenges in trying to reduce bureaucracy and streamline systems when there are multiple bodies involved in accreditation, we would not support any move to a single national accreditation agency. There are too many different and distinct profession-specific requirements for this to be either efficient or effective. A more suitable approach would be to progress the work to drive a more collaborative inter-professional approach, including MOUs and joint projects or work streams.

The Australian Medical Council has a broad remit covering all medicine disciplines as well as the continuum of learning thereby capturing efficiencies through the application of consistent and transparent standards and processes across the differing medical disciplines.

The AMC’s move to an outcomes-focused approach is proving effective in fostering strongly collaborative continuous quality improvements. This should be recognised and considered as an example of how to progress from more process-oriented models.

We do share concerns that there are aspects of the accreditation system where a lack of flexibility is hindering change and creating excessive administrative burdens, and where elements are unnecessarily complex. In particular, we consider that taking a risk-based approach to accreditation monitoring and reporting would enable a more appropriate level of oversight and active management to be implemented. This would both improve its effectiveness and remove redundant work for both the accreditors and those being accredited. This is discussed in more detail later on.

We have structured our response under the three themes of the Discussion Paper.

Improving efficiency

In relation to medical specialists, we consider the current accreditation arrangements generally to be fit for purpose. In a high risk profession such as medicine, it is vital that the accrediting body has a detailed and nuanced understanding of the challenges faced by the system as well as possible gaps, and has the appropriate expertise and organisational mechanisms to identify and monitor system improvements.

We have concerns that any move to a single national accreditation body would bring about an inappropriate level of generalisation within training programs and assessments, and weaken the necessary specialisation that is inherent within the different professions. We acknowledge the desire and need for continued improvement, but the current accreditation system in medicine has significant expertise and is delivering quality outcomes, and it’s important that this not be undermined. Equally, from the perspective of effectiveness and cost effectiveness, we understand that research undertaken by the AMC indicates that their costs involved with medical accreditation and International Medical Graduates are comparable to, or less than, those of their equivalent functions in the UK and USA.

The Discussion Paper refers to ‘common health profession elements/domains, overlaid with profession-specific requirements’, while also acknowledging that the postgraduate nature of medical specialist education renders our accredited educational functions substantially different to others. Indeed, the Discussion Paper refers to them as “unique”. The College agrees with this characterisation.

Accreditation in the postgraduate medical environment, with its focus on work-based experiences, is very different to accrediting the undergraduate providers who operate in a highly controlled teaching environment. Given that the current accreditation system for
medicine, through the AMC, provides one body that oversees the continuum of learning – from medical school through to post Fellowship – this system already achieves significant efficiencies by providing a high degree of transparency and continuity of standards and expectations for all bodies responsible for medical training. Recently, the AMC has also taken an active role in the pre-vocational years. This involvement should continue to further enhance the streamlining of medical education pathways in collaboration with jurisdictions and other training providers.

Outlined below are areas where changes could bring about considerable improvements.

1. We recognise the importance of **inter-professional benchmarking and collaboration** to improve synergies between the professions and minimise duplication. This could be achieved through the establishment of MOUs between relevant organisations and leveraging collegial networks and fora to improve the streamlining and sharing of best practice across the professions. This would build on the significant work in this area which has been initiated in the field of medicine.

2. **Taking a risk-based approach to the monitoring of and reporting requirements for accreditation** would enable more appropriate levels to be implemented, that are commensurate with the situation. Where there is a high-functioning organisation with a strong track-record, a low-risk set of circumstances where no major changes are being instigated, with effective processes already in place, then it makes sense for there to be more streamlined and less onerous – and costly - monitoring and reporting. Conversely, for accreditation of higher-risk situations, then a far more stringent and tightly managed set of conditions and timeframes would be appropriate.

3. We also recommend that a significant opportunity exists for the Review to focus effort on **improving the evidence-base for workforce planning**, including the use of common data and the sharing of data to streamline these processes and ease the administrative burden.

4. There are substantial benefits to be gained **from improved use of technology**, **including inter-operability and common platforms**, and this should also be a prime focus for future reforms.
Relevance and responsiveness

Through the nature of its standards and its practices, the AMC fosters a collegial method of driving quality improvements, and enables a strong stakeholder and consumer voice. This encourages collaboration within the sector and assists in ensuring quality improvement activities meet health sector needs.

The AMC has a broader remit than many of the other accreditation bodies. It is already acknowledged to have a strong outcome-focus within its standards, in contrast to other more process-driven approaches. Because of this, the AMC’s work is already substantially aligned with the preferred practice conceptualised in the Discussion Paper and, in our view, could serve as an exemplar or model for other professions. It is important that reforms across the system do not bring about an unintended consequence of slowing or even hampering positive developments by more progressive bodies.

The AMC’s approach to managing risk and driving reform is a rigorous review process, which identifies ‘conditions’ and recommendations related to each of its accreditation standards. Such a system is important to medical colleges in that it focuses efforts on critical change initiatives and commits to quality improvement cycles. However sometimes these conditions require the organisation to commit significant resourcing and undertake complex change, and can often have impacts beyond the direct remit of the college. Even for large and relatively well-resourced colleges such as the RACP, this can put a significant financial burden on the member-based organisation.

Larger changes, particularly those involving technology dependencies, cultural change or political sensitivities, can take substantial time. Excessively tight timeframes, which do not recognise this complexity, can inhibit rather than encourage innovation. Even where the timeframes initially appear appropriate, there is currently no ability for these to be renegotiated which can cause difficulties when externally-driven developments occur and are not able to be taken into account. Nor is there any incentive to tap into advances that could enhance or accelerate the delivery of a condition.

Further thought needs to be given to ensuring timeframes appropriately balance quality, risk, and resourcing, and to incorporating a level of flexibility so that the initial conditions and timeframes can be re-assessed and, when deemed necessary or useful, appropriately revised.

We also submit that the Review consider the approaches that are taken when establishing accreditation panels. These panel members have considerable influence on the strategic direction of the profession and their decisions have implications for many years. It is important in selecting and managing panels that processes are in place to ensure transparency as well as consistency in approach both over time and between different organisations.
Producing the health workforce of the future

Australia’s future health workforce must be equipped to serve emerging health needs and contribute to improved patient outcomes. Evidence shows that the quality of training has a lifelong impact on the physician competency (Asch 2009).

In other words, training matters.

Health regulators need to consider how they could take a more active role in fostering systemic change to support high quality training. A cornerstone in achieving this is to foster the development of improved learning environments and training infrastructure across the health sector. This is needed so Education leaders and supervisors have increased dedicated time to train; health settings provide appropriate physical spaces to learn; there are systems, processes and a culture which prioritises and values developing the future health workforce; and implement career pathways and employment conditions for doctors that recognise medical education as core to the remit of health institutions.

In addition, all training programs need to underscore the importance of system improvements including inter-professionalism, innovative models of care, and reduction of inherent geographic and socio-demographic health inequities.

New AMC standards seek to drive innovation on some systemic health issues or topics i.e. professional behaviour, wellness, patient safety, and Indigenous health. However, there must be increased opportunities for accreditation bodies to foster collaborative solutions to some of these newer standards. There also needs to be the recognition that the innovation necessary for to shape the health workforce of the future extends well beyond the role and capacity of the AMC, and the College.

Health services need to recognise their role as education providers and ensure this function is appropriately resourced and supported. They play an integral role in developing our future health workforce. Fundamental to achieving this is ensuring the quality of training remains high and isn’t compromised, and through effectively balancing service provision and training commitments.

It is also clear that health system change and innovation is more likely to emanate from the health service environments; particularly changes relating to new models of care and the health professional roles designed to support them. The future medical specialist workforce will greatly benefit from increased inter-professional learning, and needs to experience working in team-based care arrangements within their training to support their future clinical practice. Much of the reform occurring within the health workforce—for example, increasing the focus on multidisciplinary teams, building stronger connections between the acute and primary health sectors, and recognising the value of patient-centred care and shared decision-making—is driven by policies, employment arrangements and the workforce culture operating within the health services themselves.

However, there does need to be an appropriate level of oversight so that proposed new ways of working and new or revised roles can be reviewed and approved, and we recommend that consideration be given to where this function should best sit. This function would also then be able to determine the widespread applicability of successful innovations, and how any trials would progress to being a generally approved model of care or health professional role. Similar to how the AMC is adopting new standards to reinforce systemic health priorities from a medical education perspective, the health system would benefit from having specific measurable standards and conditions related to building the culture and infrastructure required for growing the medical workforce. These should be reinforced
through organisational level and health service standards such as those set by the Australian Commission on Safety and Quality in Health Care.

We’d like to make a final point on the Review’s call for increased transparency to healthcare consumers and the general public about the functions and responsibilities of the NRAS and the organisations involved. The RACP wholeheartedly endorses this view, and would like to add that there is also the need to ensure this information is understandable and meaningful. No matter how well educated, involved, or health literate consumers are, health care and educational jargon can be complex to navigate, and it’s vital that this is addressed and that plain-language guides and information resources are developed, publicized, and made easily accessible.

Conclusion

Fundamentally, and as highlighted in the consultation paper, the NRAS’s primary goal is to safeguard public safety by ensuring only suitably trained and qualified health practitioners are able to practise in Australia. No matter what changes are introduced as a result of this Review, this must remain its focus.

We commend the Review’s aim to identify key efficiencies however we urge careful consideration of their design and implementation to ensure these are balanced with and support the profession-specific requirements.

The RACP thanks the review for this opportunity to contribute to this important work of improving health accreditation and looks forward to further information and collaboration concerning this initiative.

Yours sincerely

Dr Catherine Yelland PSM

Enc:

RACP submission NRAS review 2014
1. Introduction

The Royal Australasian College of Physicians (RACP) is responsible for training, educating and representing over 21,000 specialist physicians and trainees in Australia and New Zealand.

The RACP welcomes the opportunity to provide input to the review of the National Registration and Accreditation Scheme for health professions (NRAS) being undertaken by Mr Kim Snowball on behalf of the Australian Health Ministers’ Advisory Council (AHMAC).

Our submission to this review will address the questions raised in the consultation paper prepared by Mr Snowball in August 2014, and published on the AHMAC website. There are a number of questions where the RACP feels it is not in a position to provide comment, and we have omitted these from our submission.

2. Responses to questions raised in the consultation paper

1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

The discussion paper suggests three possible functions for a reconstituted Australian Health Workforce Advisory Council (AHWAC):

- assessment of all regulators,
- provision of independent advice regarding proposed changes in the standards and
- reporting on actions within the National Scheme.

The last of these functions includes the responsibility for informing regulators about health workforce reform priorities.

We consider that, because of the disparate nature of the tasks proposed, it would not be appropriate for a reconstituted AHWAC to take on the role of the first function; that of undertaking the assessment of all regulators. This role raises important questions about the overall complexity of the scheme and the possible need for an additional set of standards for the conduct of the regulatory bodies.

We feel it would be possible however for a reconstituted AHWAC to be in a position to provide relevant advice on matters where reform programs would lead to changes in standards.

There is considerable need for a process to deliver on the third function - that of reporting on actions within the National Scheme - and this is something that we feel a new AHWAC could take on. It would be important that this role is recognised as being central to providing an effective mechanism through which there can be proper consideration of innovation and reform.

One of the main areas where innovation and new ways of thinking is most required is in ensuring we are not being restricted by the traditional boundaries of health professions. These boundaries are currently enshrined and reinforced by the current structure, particularly because of the need to deal with complaints and notifications.

2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

A reconstituted AHWAC may well be a suitable forum for resolution of such issues.
3. **Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?**

Estimated cost saving $11m per annum?

Given that this proposal does not involve modifying the framework for specialist medical practitioner education and training, the RACP does not consider it has sufficient understanding of the operations of the nine National Boards to be able to provide an informed response to questions 3, 4 and 5. We fully support operational efficiencies where possible, however it is vital that the search for efficiency and savings does not adversely affect the effective working of the organisations, and that changes are implemented in a considered manner.

10. **Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?**

The RACP recognises that the NSW co-regulatory system in medicine appears to have functioned well since the introduction of the NRAS in 2010, and notes the decision by the Queensland Government in 2012 to abandon the original structure and to move to a similar structure for all health professions.

However we consider that, although potentially attractive, the Queensland model has not yet had sufficient time to demonstrate its effectiveness.

19. **Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?**

The RACP strongly supports the revision of mandatory notification provisions to ensure there is a nationally consistent approach and appropriate protection provided to health practitioners under active treatment.

This issue also highlights the vital need for regulators to engage with professional bodies, such as the specialist medical colleges, to develop appropriate processes for providing timely advice from AHPRA and the Board about formal decisions arising from tribunals or other hearings.

This is particularly important where a practitioner’s registration has been suspended or removed. However, it also extends to allowing the colleges to undertake support and remediation roles in collaboration with the regulators where such interventions have been determined as relevant.

It is perhaps ironic to note that remediation and performance monitoring processes are mandated for colleges by the accreditation standards of the AMC, but that the appropriate delivery of these is inhibited greatly by the fact that the colleges are not generally notified of relevant determinations. This must be resolved.

20. **To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?**

Overall, the current NRAS largely delivers on its regulatory functions however its structure inhibits its ability to address issues of innovation and reform. We would argue that a much more forward looking approach to recognising specialty groups within broad categories would
be a considerable benefit to stimulating innovative thinking on a range of education, health workforce and service delivery issues.

Similarly, the overall segregation of the health professions has the inadvertent effect of reinforcing professional boundaries rather than encouraging flexibility.

The effect of the Specialist Register as a barrier to reform within the area of specialist medical services is addressed further in our response to Question 22, however it should be noted that we fully recognise the difference between the intent of the Specialist Register and the current reality of its flawed interpretation outside the immediate regulatory environment.

21. Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

The RACP is concerned that the thinking underpinning this question suggests that the innovation and reform needed in the health workforce can be implemented through a regulatory approach. Successful reform is far more likely to emerge from the profession when encouraged and enabled by the context of an accommodating or adaptable regulatory framework.

On the other hand, it is certainly true that a reconstituted AHWAC could provide important leadership regarding gaps in accessing health services, provided the recommendations were underpinned by solid modelling and data on the supply and distribution of health professionals.

The group may well be able to contribute an important perspective on how the nation's health workforce might be structured and distributed in order to best meet the needs of the community. However, we note that there does not appear to be any evidence that the current structure has encouraged or brought about genuine reform.

22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

From the perspective of the education, training and ongoing clinical practice of medical specialists, the current arrangements can actually inhibit changes to the training structures and trialing and development of new health professional roles which might better address health needs and current issues. This is especially the case with the Specialist Register, but also applies to other matters outside the scope of the NRAS (eg Medicare).

For example, the current Specialist Register has a fixed range of "protected" titles which does not appropriately cater for existing and future disciplines within recognised broad groups such as 'Specialist Physician'. All current or future graduates of the specialist training program need to fit into an existing registration category. This is required for the purposes of credentialing within a health service, for eligibility for Medicare recognition and for a range of other issues. However many of these other purposes were not foreseen in the original development of the register, or have emerged from interpretations of the register's function which differ from the original intent of having these protected titles.

Perhaps the most egregious example of this is the removal of a number of highly experienced and competent specialist physicians from consultant General Medicine rosters by administrators in a range of hospitals, on the grounds that they do not hold registration as Specialist Physicians in General Medicine. This is despite the fact that the physicians affected had served on these rosters in these hospitals for many years.
Whilst the intent of the register was never to inhibit the ongoing activity of skilled physicians, it has had the unfortunate impact of doing exactly that in a range of settings.

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

In the area of medicine, training for entry to the profession, pre-vocational training and vocational programs are all quality assured through mandated accreditation processes. The key to the success of the model is the use of well-defined standards which articulate appropriately between the various stages, focus on outcomes rather than program structure and requirements, and support a continuous quality improvement approach to program development.

An additional benefit of the peer review process is that there is a strong educational element for those undertaking the accreditation reviews. This works to promote understanding of the process and its intentions, and to spread more widely a good understanding of innovations and reform achieved elsewhere. Although the process at the level of specialty training is demanding, in terms of direct and indirect costs to organisations undergoing the accreditation process, the benefits are significant and we would not support any major change to the process.

The College suggests that there would be benefit to other regulated health profession regulators giving this model careful consideration; especially its focus on outcomes rather than structure or process.

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

The specialist medical colleges undertake assessment of specialist international medical graduates on behalf of AHPRA and the MBA under the conditions of a formal assignment of this function to each college. The current processes for assessment of specialist medical practitioners are appropriate in the broad sense, but clearer guidance from AHPRA and the MBA on implementation would assist greatly in achieving more consistency and flexibility.

In particular, there is not a sufficiently clear articulation of the way in which the objective of the NRAS regarding flexibility should be implemented.

Furthermore, the structure of the Specialist Register works against flexibility in the assessment of practitioners from international settings. Again, there are other influences outside NRAS (such as Medicare) which can also inhibit flexibility in the process; although Medicare also has the capacity to make independent determinations regarding access to specific rebate categories which can lead to increased flexibility in some cases.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?

The selection of National Board Chairs should be done through a formal and transparent selection process, and be decided on the basis of relevant skills and demonstrated experience, including leadership of groups or organisations, and specific expertise relevant to the role of the Chair.

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?
Accrediting authorities need sufficient independence from regulatory bodies to ensure protection of standards from issues of expediency, especially where potentially simple solutions to complex problems such as workforce numbers and distribution might be attractive. We acknowledge also that there are effective international models such as the UK’s General Medical Council where a single agency retains both regulatory and accreditation functions. In these cases, the effective separation of the core functions has been managed effectively within the organisations.

Given that there are a range of arrangements around the assignment of the accreditation functions of the respective Boards, our comments relate only to the arrangement between the Medical Board of Australia and the Australian Medical Council.

The RACP welcomes the extended period of assignment of the accreditation function to the AMC. The process for accreditation of programs of training for specialist medical practitioners is prolonged in all cases and the periods of accreditation for successful colleges are considerably longer than the period for which the accreditation function has been assigned. This introduces an element of uncertainty into the accreditation process which is largely unhelpful.

The successful administration of the accreditation process is heavily dependent on the scrupulous independence of the accrediting agency, and the self-review, continuous quality improvement approach with assessment by peers which underpins the AMC process is highly regarded locally and internationally.

The legislation itself provides for final approval of the accreditation decision by the regulator. In that the circumstances under which an AMC recommendation on accreditation might be altered by the MBA have yet to be discovered, this element of residual doubt leaves some concern about the true level of the AMC’s independence. It is clear however that, in the current circumstances, the arrangement functions well, issues around funding of the AMC’s accreditation functions notwithstanding.

27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

The RACP considers that there is very effective oversight of the accreditation decisions made by the AMC and its accreditation groups. We do not have a view on process undertaken in the other regulated health professions.
3. Conclusion

Much has been achieved since the establishment in 2010 of the National Registration and Accreditation Scheme. The RACP unreservedly supports its objectives to protect the safety of the public, facilitate workforce mobility across Australia, and enable the development of the health workforce required to meet Australia’s future health needs.

One of the cornerstones to the NRAS’s success is its cross-jurisdictional, collaborative and consultative organisational model. This is vital to appropriately managing the federated system in which health practitioners work in Australia and supporting their movements across States and Territories borders.

The NRAS is a regulatory system based on individuals and individual health professions. Its main focus must remain on ensuring that professional standards are maintained in the public interest. The regulatory system should not be overly restrictive; but be able to accommodate flexibility and innovation coming from other areas of the health system.

However it needs to be recognised that there are practical limitations as to how much innovation and reform can be instigated and driven by a regulatory system. Much of the reform and new approaches to future health practitioner roles and building effective multidisciplinary health teams centred on patients’ needs has to come from health policy, employment arrangements and the workplace culture that underpins delivery of health services themselves. Such reforms can also be supported through the new National Safety and Quality Health Service Standards and accreditation processes.

The RACP applauds the commitment by the AHMAC to implementing regular reviews of the scheme and seeking feedback from organisations who are both affected by it and who contribute to its success. We would be happy to provide further clarification on our comments or to participate in additional consultations.