Consolidated list of issues
Improving efficiency

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?
Greater consistency and commonality in development and application of accreditation standards may mean universities with multiple programs have streamlined reporting on common elements. Care should be taken that commonality does not erode unique professional elements of each program.

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?
Yes, these decisions should be taken into account in any reviews undertaken by accreditation authorities.

3. What are the relative benefits and costs associated with adopting more open-ended and risk managed accreditation cycles?
Nursing have moved to risk management/reporting models. If this model was to be effective it would require education for course coordinators and panel members about identifying risk factors and the level of risk they may pose. Care should be taken in this model to ensure that:

- it does not become more onerous than current annual reports,
- trends are not missed with lack of annual reports, and
- rigour is maintained without an annual report.

Before making any decision, consultation with nursing to evaluate the benefits and costs of this model would be beneficial.

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and inter-professional collaboration?
Panels require ongoing education and training to ensure consistency. Reducing the number of panels could also achieve better consistency, although this would increase the workload for those panel members. Including a panel member from another profession could also help with consistency. If commonality across professional accreditation bodies is to be implemented, panels will require adequate training to evaluate how effectively a program is meeting standards specific to that discipline.
5. Should the assessment teams include a broader range of stakeholders, such as consumers?

   If consumers/stakeholders are to be included they will need to be cognisant of the education required for specific disciplines and made fully aware of the full scope of practice of that profession.

Sources of accreditation authority income

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

   At present the universities bear the brunt of cost of accreditation and it would be helpful for government to accept some more of the responsibility for training their health workforce.

7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

   Fees should reflect the work required in verifying overseas qualifications, reflect the work of conducting the cognitive assessment in the home country and the competence assessment in Australia. It definitely should cost more than internal applications.

   In Nursing and Midwifery, much work is in progress looking at outcome-based assessment of competence to practise for all internationally qualified registered nurses, midwives and enrolled nurses. This is similar to Allied Health.

Relevance and responsiveness

Input and outcome based accreditation standards

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

   Graduate outcomes should be the focus of an accreditation standard but in some instances rather than list every individual student outcomes, input or process may be warranted.

   For example in Physiotherapy, rather than every clinical placement of every graduate being provided in a complex matrix it could be more appropriate to have a process whereby the program reports on what processes are used to ensure that all students meet these accreditation requirements.

Health program development and timeliness of assessment

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

    A common approach to the development of a professional competency framework could be useful but the individual elements of the framework should remain profession specific. A person from another profession cannot mandate standards for a particular profession without impacting on that profession’s expertise in their own field.

    Surveys establishing feedback from consumers, students and other professions would be valuable but these groups should not be dictating curriculum. Consumer feedback is important but a consumer cannot mandate standards for the practice of a profession.

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

    Some common health professional elements could be included and the benefits are the same as those above. Care must be taken not to over-ride/devalue discipline-specific elements or even lose profession-specific requirements.
The establishment of too many Interprofessional or Interdisciplinary elements in a course is that inevitably the “common denominator” must be reached. So while a small amount is appropriate, the profession-specific depth must not be lost.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?
The combination of accreditation processes and ability for education institutions to make change mean that any changes in curriculum are a lengthy process with minor changes taking at least 12 months and major changes taking 12-24 months. Accreditation authorities need to understand that when they stipulate changes in curriculum it will not happen quickly.

By implementing a clinical education reporting system as described above the universities can at least provide clinical placements that better reflect professional attributes required in current and future workforce. In physiotherapy this trend is away from the public health system, where jobs are being lost, into the private and NGO systems.

Other issues that are also involved in this element to prepare graduates for current and future workforce trends are

- lack of funding for clinical placements within Allied Health. Currently universities are required to pay for clinical placements in all sectors of health and this may limit access to certain areas of health.
- lack of allocation of funding in NDIS to account for student treating patients/clients under this scheme compromising students’ opportunity to be work ready for the disability sector
- prohibitive costs of placing students in private practice (despite more than 50% of graduates working in this sector) because the practitioner supervising the students cannot see as many clients themselves and lose income. Universities cannot match this cost.
- private health cover does not allow for student treatments, thus further limiting student engagement in this area and again compromising opportunities to be work-ready in this sector.

Interprofessional education, learning and practice

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?
Interprofessional practice is more than sharing lectures – students need to be discussing their roles and the roles of other health disciplines to develop a shared understanding. Students engaging in these activities do not need to be exposed to all health professionals but need to develop insight into the roles and responsibilities of other professions and how they may work collaboratively. Care must be taken in this element not to prescribe something that cannot be achieved by smaller universities who do not have multiple Allied Health programs.

Another factor to consider here is reality, because currently students who have experienced IPE at University and understand collaborative work find that once exposed to the clinical world that this is not how the health system operates. Some major overhauls of health will be required before teaching innovations in this element translate into changes in the workplace. This is an example of students being taught best practice without being able to translate into practice.
Clinical experience and student placements

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?
   The cost of using simulation of a good quality is prohibitive to Allied Health programs embracing it more fully. The HWA funded study undertaken by 16 Physiotherapy programs across Australia identified that well-resourced simulation can be used to enhance, not replace, clinical placements but it is very expensive. While simulation is an important teaching tool it cannot be and should not be used to replace "real patient" contact and experiences. Clinical placements remain a pivotal aspect of the health professional student’s experience.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?
   No. While Medicine has a mandated internship for registration which is essential and supported by the State Government at this time, an intern year for a Physiotherapy graduate would need to include rotations in public hospitals, NGOs, private practices and private healthcare facilities. Who would pay for students and how would they be assessed to have met registration standards? How is this different from current final year clinical placements?
   Currently Physiotherapy students on clinical placement are assessed to determine if they have reached graduate entry level. This assessment is a national tool used by all programs in Australia and New Zealand - the Assessment of Physiotherapy Practice (APP). Would students be required to complete all these clinical placements as well as an internship?

17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?
   The definition provided in the APP is a good definition. It identifies that a new graduate should be able to assess and treat non-complex patient in a timely manner while recognising their own limitations. The Nursing and Midwifery Board of Australia’s Decision Making tool is a comprehensive framework that provides nurses and midwives clear guidance in terms of scope of practice, delegation, mentoring and supervision.

   There is continued debate over the need for a standard national exit examination for Medicine. An exit exam would provide parity for graduates for international practice and while a burden to the student, could create a level playing field across institutions. It could also support the notion of graduate outcomes.

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration?
   Yes
   Alternatively, does a national assessment process allow for a more streamlined accreditation process?
   Different courses respond differently to this question.

Producing the future health workforce

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?
   Physiotherapy Board members do have appropriate knowledge as they are practicing physiotherapists or physiotherapy academics. National Boards need to have capacity to manage accreditation standards
founded against evidence-based practice and not only against common practice. In some instances graduates/students find it difficult to implement evidence-based practice because either the health system cannot accommodate or clinicians have not kept abreast of developments.

The National NMBA with the support of the NMBA State Boards have appropriate skills and knowledge to determine accreditation standards and have a collaborative relationship with ANMAC to ensure programs of study meets current and contemporary practice.

The current composition of AHPRA and the way complaints are reviewed by non-medical professionals is not of assistance to the medical profession. It does not ensure a safe and quality outcome for the consumer. The SAT process for Appeals does seem to be robust.

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers? The accreditation authorities cannot work without the involvement of the profession.

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions? It appears that there is currently no community representation in Physiotherapy accreditation decisions, however, it would be prudent to have someone on each panel who does not have any perceived conflict of interest (ie. Not a member of another University physio programme or works in the profession) to ensure there was no intentional or unintentional bias in assessment.

There is an assumption that there is consumer representation on the Medical Board/AHPRA as they are represented in complaints.

The NMBA National and State Boards do already have a number of community representatives on each of the Boards.

Role of accreditation authorities

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS? Yes

What other governance models might be considered?

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

Current governance model is working well for the Nursing and Midwifery profession but ensuring efficiency of processes and streamlining functions of each governing body is necessary.
26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?
The only way this can be achieved is through all professions being aligned and having a shared understanding of cross-professional competencies.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?
As a minimum, an external review should be conducted annually within each profession to ensure that all programs are being asked to provide the same information and are being assessed against the same competencies. For example one panel may insist a program provide specific types of clinical placements for all students (paediatrics) while another panel may not see that this is an essential element. The outcome being that both programs are being asked to provide different things for accreditation.
Looking more widely between professions an external reviewer could ensure that Interprofessional requirements are assessed at the same standard regardless of whether discipline specific elements are assessed at a different standard.

Setting health workforce reform priorities

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?
There does not appear to be any regulation/correlation between the number of new programs and either employment opportunities for graduates or the ability of current and new programs to find appropriate clinical placements to ensure graduates meet registrations standards. Maybe more due diligence is required so that all graduates have a good chance of employment and also so that current programs that continue to meet accreditation requirements are not jeopardised by losing clinical placements to new programs. It could be a requirement that new programs indicate how they will provide clinical placements for their students without impacting on existing programs.
It might be the role of the Ministerial Council to determine whether new programs are going to lead to an oversupply of health professionals in the workforce.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?
In theory – no.

33. Is there a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?
No

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?
Yes
Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

There should not be a ‘one size fits all’ - rather each application should be considered and whatever measures are required for that individual based on previous experience and education are the measures that should be adopted for that individual person.