10th October, 2014

Mr. Kim Snowball  
Independent Reviewer  
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Dear Mr. Snowball

Re: Submission in response to the *Review of the National Registration and Accreditation Scheme for health professionals: Consultation Paper, August 2014*

Flinders University welcomes the opportunity to provide feedback on the *Review of the National Registration and Accreditation Scheme for health professionals: Consultation Paper, August 2014*. We note that the National Scheme has been in operation for just over four years and commend the Australian Health Ministers’ Advisory Council for initiating this timely review.

Our response below consists of comments in response to the questions identified in the Consultation Paper.

We note there has been some variation in the way institutional accreditation fee structures have been applied across the professions. In this context, consideration should be given to addressing harmonisation across all relevant professions. In the case of Occupational Therapy and Physiotherapy, we have experienced the introduction of a new accreditation fee structure during an existing accreditation cycle. In circumstances such as this, there is no simple process for recourse with the regulatory body. On the basis of the above, we suggest the following two points for further consideration:

- harmonise the alignment of accreditation fee structures with accreditation cycles across professions; and
- implement a simple mechanism for resolving issues relating to accreditation processes.

There is a need for an independent review process of the National Scheme. A mechanism for resolving issues is required. Issues relevant to specific professions do need an avenue to be addressed although there may be disagreement by individual professions to this idea. Provided it highlights an avenue for discipline-specific issues, a single review entity may be helpful in ensuring consistency of accreditation decisions across professions. For example both the new occupational therapy and physiotherapy programs at Flinders University were successfully accredited, however occupational therapy was awarded accreditation for 5 years with two recommendations to provide information – on graduate outcomes (recommendation 1), and benchmarking (recommendation 2) 1 to 2 years post the first graduates of the program – whereas physiotherapy was awarded accreditation for 2 years with the above recommendations stated as conditions. This variation in decisions is difficult to understand when both programs received very positive reports from their panels with many commendations.

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Risk to the public should remain the key criteria for inclusion of a profession in the National Scheme. If for a particular profession there is no demonstrable risk to the public, the benefits for including this profession in the National Scheme would be difficult to justify. However, given the possibility there may be variation in how notification data is recorded and reported in professions outside the National Scheme, there is the possibility that some professions may be at a disadvantage in terms of achieving the relevant inclusion threshold. Inclusion threshold criteria could be realigned to address any profession-specific reporting variation.

In addition, there are professions currently outside the National Scheme which perceive a real need for inclusion. Inclusion in the Scheme would provide professions such as paramedics with access to a more nationally consistent system for transparently addressing complaints and misconduct as well as recognising risk to the public.

We have experienced reluctance from the side of regulators in supporting the introduction of innovative educational techniques into clinical practice, such as simulation and inter-professional learning (IPE), which are aimed at meeting future health practitioner skill profiles. There are also limited opportunities to gain funding for research into the development of such techniques.

We recognise that the perspectives of educators and regulators vary somewhat. From the educational management perspective, it is a complex issue balancing the delivery of a high quality educational program which is both aligned to accreditation standards and able to be maintained in a financially viable fashion. We agree there is a need to introduce a process for educators and regulators to collaborate on questions of professional minimum qualifications and to ensure the existence of programs to qualify individuals to practice.

Whilst we acknowledge that the AHPRA has increased mobility of doctors across State borders, which is a good result, it has also meant that reforming the links between the various levels of medical training has become more difficult. As an example, both medical schools in South Australia have a significant emphasis on rural training in their medical courses. There is also excellent vocational level training in rural general practice available in South Australia. However, in between these two levels is an intern year that is almost entirely focused on city practice in Adelaide. This breaks the ‘rural pipeline’ which in turn significantly diminishes the effect of the effort that both universities have committed to on improving access to doctors in rural areas. It is evident that students who are keen on rural practice become exposed and re-attached to city professional and social life which in turn reduces the attractiveness of returning to a rural or remote location.

One way to overcome this would be for the two universities to develop an alternative pathway to general registration for their students, thus enabling them to stay in rural communities during the transition between medical school and rural GP training. Both universities are keen to pursue this and there is support from within SA Health. Other jurisdictions have more opportunities for rural internships, so the problem is not as acutely felt as it is for South Australia. Such a reform would likely be much easier to achieve if jurisdictions were given the capacity to convene sub-committees empowered to tackle and resolve jurisdictional issues, such as medical licensing in South Australia. Under such a model, all relevant stakeholders would have the opportunity to develop and agree on a reform plan in a more locally relevant group with a clear and common societal interest. With the advent of AHPRA, all jurisdictions would have to agree, thus not allowing South Australia to pilot an approach that could then be examined by the other jurisdictions and either taken up by them, or not, as required.

Flinders University is happy to provide any additional information on the above feedback as well as enter into further dialogue with the Review Committee should this be required.

Yours sincerely

[Signature]

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