National Registration and Accreditation Scheme for the Health Professions Review Submission in Response to the Consultation Paper, August 2014

Introduction

The establishment of the National Registration and Accreditation Scheme (NRAS or the Scheme) is a very significant achievement that the Australian Medical Council (AMC) acknowledges and strongly supports. As an accreditation authority that operated under the previous patchwork of Commonwealth, state and territory Acts of Parliament and individual health profession boards in each state and territory, the AMC appreciates the enormity of the adoption of a single national regulatory structure with national registration requirements and national accreditation processes for each profession encompassed by the Scheme. The establishment of a single regulatory structure with nationally consistent policies and protocols, and the consolidation of infrastructure to support registration and accreditation systems was a monumental task and, despite some remaining challenges, is a major policy success.

As a comparatively large and high risk profession, when the National Scheme began the medical profession was in the privileged position of already having negotiated and introduced provisions reflecting many of the regulatory structures and functions mandated under the NRAS, such as national accreditation standards and processes, and since the introduction of the 1992 Mutual Recognition Scheme increasing uniformity in registration. As such, the transition to functioning under the National Scheme has been relatively seamless for the profession. Well-established regulatory roles, relationships and processes in place between the medical boards, the AMC, education providers and professional bodies were able to be largely transitioned to sit under the uniform NRAS framework.

The AMC, from its perspective as a standards setting, examinations and accreditation body, sees the success of the transition to the National Scheme as a series of systemic improvements building on strengths in the Scheme’s design, on which any future iteration should seek to capitalise. These include:

NRAS achievements

- the establishment of a legislative basis for all accreditation activities under the National Law;
- the development of nationally consistent standards for registration and accreditation in the 14 health professions captured by the Scheme;
- the establishment of a single reference point for registration standards and policies, which has:
  - facilitated the mobility of the health workforce through a single national registration process;
eliminated many of the jurisdictional impediments to cross-border delivery of health services arising from the previous state-based regulatory systems; and allowed for improvements in operational efficiency, such as the streamlining of the Competent Authority pathway for the assessment of International Medical Graduates.

**NRAS strengths**

- the effectiveness of program accreditation as a quality assurance mechanism and in supporting continuous improvement in programs at relatively little cost to the Scheme;
- the independence of the accreditation functions and decision making, which is an important factor in the international recognition of AMC’s process, coupled with a quality assurance process for regular review of these functions.

Much has been achieved in the first four years of operation. The AMC appreciates the opportunity to contribute to the Review of NRAS, and to improvements to the Scheme’s efficiency and effectiveness. The AMC sees the consultation paper as a useful evaluation of the National Scheme’s performance against its objectives with thought-provoking options for its future operation.

The AMC has provided responses to the individual questions posed in the consultation paper, with more general comments in relation to the overarching themes for each set of questions.

In making this submission, the AMC wishes to stress the strong working relationship it has with the Medical Board of Australia, characterised by good communication, open sharing of information, regular meetings, and involvement of national and state Board members in appropriate AMC processes.

**Theme: Accountability**

The NRAS is a large and complex regulatory framework, set up to achieve important objectives relating to regulation for public safety, health workforce reform, and high quality education and training.

It is important that there is public accountability for the work and achievements in the Scheme, and the AMC strongly supports improved reporting, accountability, and enhanced communication on the operations of the Scheme.

The AMC supports continued review of the efficiency and effectiveness of the Scheme’s operations. While there are significant implementation costs associated with the introduction of the systems and processes necessary for such a large scheme, now that it is operational, continued monitoring is necessary to ensure opportunities are taken to consolidate and streamline processes.

In relation to funding, Section 12 of the Intergovernmental Agreement which established the National Scheme indicated that the fee charged to register health professionals under the NRAS was to include elements relating to both registration and accreditation:

The resources of the scheme will comprise fees received for registration functions and accreditation functions, appropriate resources of the registration boards, current Commonwealth, State and Territory contributions to registration, accreditation and
related workforce functions and a contribution of $19.8 million to the establishment of the new scheme agreed by COAG.¹

The Intergovernmental Agreement also makes clear that in the longer term the Scheme should be self-funding. As the Scheme is intended to meet public good objectives, the AMC queries whether it is appropriate for the health professions, and principally the registered practitioners, to bear its full cost. It believes that as new processes and outcomes are expected of the Scheme, such as potential changes to reporting requirements, and an increased focus on multi-profession developments, whether the registration fees of individual health professionals alone should fund those developments needs to be kept under review.

There have been significant efforts to communicate about the Scheme, through the Australian Health Practitioner Regulation Agency (AHPRA) and National Board communiques, and documents such as the joint document by the Health Professions Accreditation Councils Forum, the National Boards and AHPRA, Accreditation under the Health Practitioner Regulation National Law Act. Nevertheless, from its interactions with professional bodies, education providers, individual practitioners, members of the community and international medical graduates, the AMC observes that the key features and responsibilities are still not well understood. Stakeholder feedback received as part of the Review also suggests there is still variable understanding of the Scheme’s objectives, scope, and of the role of the regulatory bodies and functions. This limits the utility of the Scheme to institutions and individuals.

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

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

Response to questions 1 and 2

The AMC believes that the proposal to reconstitute the Australian Health Workforce Advisory Council is sensible. The AMC understands that this proposal is not intended to increase regulation above the current arrangements, and that that a reconstituted Council would draw on available information, data and reports, rather than require resources to commission new work. The AMC supports this idea.

Depending on any revisions to the terms of reference of the Council, the membership would need to be reviewed so that it has appropriate expertise for the role.

Concerning cross professional issues, a smaller oversight or initiating group supported by multi-disciplinary expert panels to deal with specific cross professional issues may be effective. The AMC stresses the need for a forum for stakeholder consultation on these matters.

The AMC would be concerned if this body became of itself an agent for change with a separate health workforce agenda rather than complementing the workforce functions which are now to be carried out by the Department of Health.

Further discussion is required regarding reporting on the operations of the National Scheme, including the information needed to monitor its performance and ensure transparency. Some

¹ Intergovernmental Agreement Clause 12.1
of the measures used in the UK would be appropriate, but there the regulators administer all aspects of the system including accreditation, registration, and professional regulation. The absence in the UK of an independent body undertaking accreditation assessments and overseas trained practitioner assessments necessitates a high level of reporting to ensure transparency and adherence to standards. In Australia, accreditation councils are already reporting to their national board every six months on their performance. The AMC would support elements of this six monthly reporting being incorporated into a framework of reporting to the AHWAC if the reporting workload is not increased.

As explained in detail in response to question 21, in order to achieve efficient, directed and effective workforce reform and address cross-professional issues, there is a need for a decision-making mechanism with authority over workforce planning and appropriate legislative backing to undertake this task. This mechanism does not need to sit within the NRAS, since the challenges of workforce reform are greater than the matters covered by the Scheme. Registration and accreditation can facilitate or enable workforce reform, but cannot in isolation be primary drivers. The process for engaging all relevant bodies in this process is crucial.

**Theme: The future for regulation of health practitioners in Australia**

The AMC agrees that there are some unintended consequences of the current structure of the Scheme, which applies the same regulatory mechanisms to each profession covered by the Scheme irrespective of size, regulatory workload or the level of risk to the community.

The debate concerning regulation of the nine professions with low regulatory workload that are included in the Scheme highlights some of the difficulties in attempting to establish a Scheme with a single uniform regulatory approach for all participating professions.

A ‘one size fits all’ model has the potential to lead to over regulation through lack of flexibility. In addition to considering the appropriate structure for the professions with small regulatory workload, some measure of flexibility in the standards that apply to the professions in the Scheme is also warranted. For example, the development of a definition of “practice” in 2011 highlighted differences in the issues confronting some professions, with considerable concern expressed by the medical profession about the potential of the definition to prevent retired and non-practising medical practitioners from participating in non-clinical activities such as teaching, assessment and accreditation.

Another example where flexibility may be diminished by a cross profession approach is the recognition of specialties within a profession. The National Law provides for specialist registration, and describes the role of the relevant national board in advising the Ministerial Council on the list of specialties and the specialist titles for the listed specialties. In 2002, the AMC established criteria for the recognition of medical specialties. Prior to the NRAS it assessed applications against those criteria and submitted advice to the Commonwealth Minister for Health. The AMC understands that a cross profession approach to a recognition process and criteria is being developed, with criteria that draw heavily on the work of the AMC. While the AMC agrees that these principles and its overall processes for the recognition of new medical specialties could be applied in other areas, this would need to include suitable modifications and appropriate professional and stakeholder input.

In any regulatory structure for the professions it is critical to retain input of the professions to the setting of standards and national board decisions, and for members of the profession to contribute to the peer review processes which characterise good accreditation. The AMC
notes this approach is supported by reports that regulatory goals are more likely to be achieved with regulation that has “buy-in” from those being regulated.2 The continued strong engagement of the professions in expert tasks, such as setting standards, accreditation of programs, assessment of practitioners and national board approval of programs for registration purposes is essential for the continued success of the Scheme.

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

4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving $7.4m pa.

Response to questions 3 and 4

The AMC agrees that separate boards and regulatory functions should be retained for those professions with high regulatory workload.

While the concept of centralising registration and related activities for those professions with lower regulatory workloads may improve the efficiency of the Scheme, the need to maintain buy-in by the individual professions in any such change is essential. Without professional input, many of the activities required under the National Scheme would become more difficult to conduct. They will also become more costly, if the significant under-funded and unfunded contribution of individuals’ time and expertise is diminished by reduced engagement by the members of the profession.

A mechanism to provide for regular review of which professions are included in any consolidated regulatory structure may be needed. As the scope of practice of a profession increases, for instance through gaining the authorisation to prescribe, the regulatory workload is likely to change and regulatory rigour may need to be adjusted to be appropriate to the risk to the public.

The AMC notes that the UK Health and Care Professions Council (HCPC) has been used as a basis for cost comparison for similar professions regulated under the Australian system. The HCPC regulates 16 professions, about 60% of which are not regulated in the NRAS, such as arts therapists, biomedical scientists and clinical scientists. That these professions are not regulated in Australia suggests that they are not seen to pose a high level of risk to the community. In the UK, this enables the HPCP to require practitioners re-register every two years not annually. In addition, in the UK, other regulators are responsible for about two-thirds of the professions covered in Australia by the National Scheme.

For these reasons, while elements of the model have merit, it is not directly comparable or applicable to the Australian situation. Furthermore, in the UK model the regulator carries out both accreditation and registration functions, which is not the case in Australia. The model presented in the consultation paper to consolidate regulatory functions for the nine professions with lower regulatory workloads does not explore the implications of this change.

---

for the accreditation functions of these professions. It is critical to ensure continued appropriate professional input in accreditation functions, and more discussion is required on how this will work.

5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

Applying the "no cross-profession subsidisation" policy under the National Law would mean that many of the savings generated by streamlining the lower regulatory load professions must be returned to the members of those professions in the form of reduced registration fees. However Options 1 and 2, which would consolidate the regulatory structure for those nine professions, raises questions as to whether the cross subsidy policy could still apply in a strict sense. Pragmatically, it seems that under a combined structure for the nine lower regulatory workload professions, cross-subsidisation would instead need to be managed and limited through a policy approach, rather than the current strict provisions of the National Law. Would the "no subsidisation policy" still apply to the five professions of higher regulatory workload?

A significant issue for the efficient and effective functioning of the National Scheme in that it does not have mechanisms for funding cross-profession/multi-profession innovation and activities between all 14 professions. This problem may be reduced for the nine professions with consolidated regulatory functions, but a more formalised strategy for ongoing dedicated resourcing for this work across all professions is required if multidisciplinary collaboration is to be more than a secondary consideration.

In the accreditation area, the Health Professions Accreditation Councils Forum provides a coalition of the accreditation councils of the regulated professions which work together on issues of national importance to the regulated health professions. All eleven councils contribute to the work and resourcing of the Forum. The AMC has provided the Secretariat of the Forum since 1997, and funded this from 1997 to 2014.

All professions could benefit if some of the savings achieved through this Review process were allocated to cross-profession work, which would maximise further efficiencies, and contribute to delivery of the workforce reform objective of the Scheme. Should either Option 1 or 2 be adopted, a parallel amendment to the cross subsidisation provisions of the National Law could be made to protect its intent, whilst recognising and providing a modest degree of funding for mutually beneficial multidisciplinary activities across all professions under NRAS.

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

Response to questions 6, 7 and 8

The primary function of regulation should be to protect the community, and as such, consideration of any new groups to join the National Scheme should be based on the potential
risk of doing harm to the community. It is important that the rationale for the Scheme and its purpose is communicated clearly. Participation in the Scheme should not be a process to validate or enhance the status of the profession or group, nor should it be used to exclude non-regulated professions from processes which are not related to the Scheme.

There is a large number of unregistered practitioners offering a wide spectrum of healthcare services to the public. Some practitioners may have had some training, some may not. This raises the issue of the potential difficulty of defining what a healthcare provider is. Although the incidence of complaints per practitioner may be low, the total number of complaints may be large. Where other measures exist that could provide consistent protection to the public on a national basis (that is without variations in standards between the states/territories) they should be relied upon before contemplating participation in the NRAS.

Subject to the re-constitution of the Australian Health Workforce Advisory Council (as per response to question 2) it would be appropriate for this group to consider and make recommendations to Health Ministers on new professions joining the National Scheme.

**Theme: Complaints and notifications**

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?

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

11. Should there be a single entry point for complaints and notifications in each State and Territory?

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

**Response to questions 9 to 15**

Navigating through the health professions regulatory environment, as seen in the submissions to the 2013 Victorian Legislative Council Inquiry into the Performance of AHPRA, the 2011 Senate Inquiry into the administration of health practitioner registration by AHPRA and the House of Representatives ‘Lost in the Labyrinth’ Inquiry into Registration Processes and Support for Overseas Trained Doctors, is not simple nor intuitive. For this reason, where a person needs to make a complaint about healthcare or a health care professional, the AMC agrees there should be a streamlined system which could include a single point of entry for complaints.
Given health service delivery is primarily a state and territory-based function there is merit in considering a co-regulatory model for complaints and notifications in all jurisdictions. However, the costs of this proposal have to be considered, and specifically whether it leads to increased costs, cost shifting and duplication. There would need to be accountability across the management of complaints not just for those managed within the Scheme. In addition, if jurisdictions opting to handle these processes receive funding from AHPRA there is potential for a negative impact on the economies of scale for those jurisdictions that continue to use the centralised NRAS system. This issue may warrant further investigation.

The data on complaints and notifications indicates that these range from vexatious complaints and relatively minor communications issues to significant performance issues and negligence or serious misconduct matters. That would suggest that the current NRAS model should be fine-tuned to:

1. Establish a single point of entry for all complaints at a jurisdictional level with well documented timeframes to respond to complaints;
2. Provide a triage process to review complaints and notifications to separate those that do not amount to a conduct or disciplinary matter under the National Law from those that do;
3. Improve performance assessment provisions and non-disciplinary remediation processes; and
4. Adopt within each jurisdiction a mechanism for alternative dispute resolution to handle less serious matters identified through the triage process.

When timeframes and performance measures are developed, there needs to be appropriate consultation to ensure that they are appropriate to the obligation at each step of the process. For instance the hearing of a complaint may take a health complaints commissioner a long time from initiation to final decision, but the timeframes provided for others input into the processes may be very short. In determining timeframes for major and minor processes, the resources necessary to meet them must be considered. In a co-regulatory model, there is a concern that if timeframes are not being met in one part of the model, the work may be pushed to another part. Process design must consider and manage this issue.

It is important to recognise not only the notifier or complainant’s interest in a timely resolution to the complaint, but also that such an outcome is desirable for all involved, including the health professional/s, the institution involved and the public. In this context, timely resolution involves not just the finalisation of the complaint within an appropriate time period, but also the setting and communicating of time limits to apply to all participants (including the regulators) and the enforcement of compliance with those time limits.

A formal mechanism for communication and exchange of data should be established between the national boards and the relevant state officers (Health Care Complaints Commissioners or Ombudsmen). The exchange of data and information should be mandated by legislation.

The decision to remove from publication findings about a practitioner should be related to the level of risk associated to the community in relation to the specific finding. If the findings are relatively minor and correctable (through remediation for example), they could be removed when the relevant board is satisfied that a risk to the community no longer exists. If there is any risk of recurrence, there would be a case to retain the record of the findings. The US Federation of State Medical Boards has done some work in this area, notably based on studies undertaken by the Medical Board of Washington State in the late 1990’s on sexual
misconduct issues). The AMC supports the view that the date for review/removal of findings should be set when the findings are imposed.

Based on stakeholder feedback, there seems to be a reasonable argument for notifiers who are personally involved in an incident to be treated differently from those who are not. An individual personally involved in an incident that leads them to make a notification against a practitioner would reasonably expect more information in relation to the investigation and resolution than an individual making a notification in relation to an event that did not concern them personally. Review of the notification system should consider this.

**Theme: Public protection – protected practice, advertising, cosmetic procedures and a national code of conduct**

The consultation paper has a strong focus on the performance of the National Scheme in terms of protection of the public. Accreditation plays a vital role in providing assurance of the standards of education and training for practicing health professionals and ensuring a high standard of health care for the community. It is important to acknowledge and discuss funding limitations that may jeopardise its ongoing effectiveness.

Professionals are eligible for registration under NRAS only if they have completed a program of study accredited by the relevant accreditation authority and approved as a qualification for registration purposes by the relevant national board or, for overseas trained health practitioners completed one of the national pathways for assessment. Thus, the accreditation and registration functions are interlinked.

Accreditation is funded partly through fees charged to the relevant education providers for accreditation functions, and partly from registration fees collected for each profession under the National Law and allocated to the accreditation council. The level of funding for accreditation activities provided under the National Law is subject to formal negotiations each year with AHPRA and national boards and specified in the accreditation agreements. The funds allocated to accreditation functions by the boards are only a small percentage of the overall funding of the Scheme given the critical importance of accreditation in ensuring that health service is provided by safe and competent health practitioners. In the case of medicine, approximately 5% of the income from registration fees is provided for accreditation activities, of which 4.4% relates to accreditation activities conducted by the AMC. The remainder of the registration fees are committed to activities of the Medical Board of Australia (approximately 20%) and to supporting the AHPRA infrastructure (72.6%)\(^3\). The sense of accreditation councils is not that a considered decision is made by AHPRA and the boards as to the appropriate amount to properly fund accreditation authorities’ activities, but rather that the amounts allocated are those that can be “spared” from their allocations to their own activities.

In the start-up phase of the National Scheme many accreditation councils (large and small) have struggled with increased expectations and reporting requirements while operating under the funding provisions from the National Scheme. An example of increased expectations is in the development of accreditation standards. Accreditation councils are required to undertake wide ranging consultation on new and revised standards. While this is good practice, and has always been a feature of the AMC’s development of standards, the AHPRA procedures for the development of accreditation standards extend the consultation required, including review of the potential regulatory impacts, and will in future require consultation with the Office of Best

---

\(^3\) Source: AHPRA Health Professions Agreement for 2012/13, p.14
Practice Regulation to seek advice about the regulatory impact of the proposal and whether a regulatory impact statement is necessary. The monitoring of accredited programs is also an area where expectations have increased to ensure compliance with the National Law.

In some cases, accreditation activities undertaken as part of the National Law have been cross subsidised by other activities of the accreditation councils. The total cost of the accreditation functions conducted by the AMC in 2013/14, as specified in the Agreement with AHPRA, was $22.081 million and the total funding provision from AHPRA was $2.295 million.

Given the co-dependence of all aspects of the Scheme, appropriate resourcing of the accreditation functions is essential to achieve the objectives of the Scheme. Further, the current requirement for councils to re-negotiate funding every year, despite their assignments running for periods of three to five years, is inefficient, impedes longer-term strategic planning and thereby reduces the overall effectiveness of the Scheme.

16. Are the legislative provisions on advertising working effectively or do they require change?

The efficacy of legislative provisions to control advertising for the public benefit is a matter for the boards to address. However in considering this question, the AMC notes community expectations about the range of information available, such as areas of specific interest or practice, have changed and should be reflected in the regulation of advertising. Further, the AMC agrees that the practical limitations on regulating social media need to be reflected in updated legislation.

17. How should the National Scheme respond to differences in States and Territories in protected practices?

The advantage of a National Scheme is that individual members of the community should be able to enjoy the same standards of practice and protection under the regulation irrespective of their location. This suggests that there should be harmonisation of standards across all jurisdictions. Experience with the 1992 Mutual Recognition Scheme indicated that the absence of harmonisation of related regulations, such as the various jurisdictions’ poisons legislation, could adversely impact on the capacity of the regulatory system to maintain standards for the registration of medical practitioners. Harmonisation should not be limited to protected practices but should include all legislation and policies that impact on health services that are captured under NRAS.

18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

The AMC supports the introduction of a National Code of Conduct for unregistered health practitioners. It believes national boards and health consumers are better placed to comment on whether other mechanisms are required in the National Law.

Theme: Mandatory notifications

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 Western Australian mandatory notification exemptions for treating practitioners seem sensible from a long-term public protection perspective. However, to ensure the exemption is consistently and appropriately applied, clear good practice guidelines are needed to assist treating practitioners in making the critical decision about the point a short-term risk to the public might outweigh the longer-term benefits of applying the exemption to mandatory notification.

Theme: Workforce reform and access

The consultation paper analyses the National Scheme’s performance in delivering on its objectives in relation to workforce reform and access, and proposes options for providing more coordinated action. This is arguably one of the more challenging objectives of the National Scheme, and one for which the performance of NRAS has been criticised. Comparable regulatory schemes internationally do not include objectives in relation to promoting health workforce reform. These agendas are broad responsibilities of employers including all governments, and perhaps the expectations and responsibilities of the bodies under the Scheme for workforce reform need to be better articulated. The AMC sees these responsibilities as including: providing data, contributing their expertise to policy development, ensuring that their own functions allow for and enable a flexible response to governments’ workforce agendas, and identifying and addressing consequences of workforce reform for public protection through public consultation and changes to standards and requirements.

Additionally, to properly examine this issue, the term ‘workforce reform’ needs to be defined. The term tends to be used interchangeably when referring to implementing minor task substitution between professions, through to large-scale restructure of the workforce, which are entirely different propositions. This differing understanding has implications for what systemic changes are required to deliver the desired outcomes.

For workforce reform to be effective, the determination of required reforms must involve first identifying the need, such as a practitioner shortage, career structures to retain practitioners, or improvements in the quality or acceptability of care. This is followed by an assessment of whether there are external structural or logistical barriers. For example, are shortages in a particular profession due to financial or infrastructure considerations, industrial restrictions or the inability to train sufficient practitioners to meet the need?

Assuming the cause is not external, the next consideration should be whether there are existing training programs that can meet the particular workforce need, and if not, the focus moves to the design and introduction of appropriate programs. The accreditation and registration process then becomes relevant through the development and application of appropriate standards to ensure quality and continual improvement in education and training, whether for new programs or existing or modified courses of study. In this way, accreditation is a longitudinal contributor to reform, but cannot be expected to drive short-term change.

Workforce reform occurs through bottom up as well as top down change. Medical research and scientific development, technological change and practice innovation create profound changes in patient care and medical practice, including the development of new fields of specialty practice. Evolutionary changes are incorporated in the training of medical practitioners as they occur.
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?

Delivery of these objectives is reliant on interrelated responsibilities of various bodies under the National Scheme and organisations such as Departments of Health. As has clearly been recognised in the review, the absence of an overarching workforce agenda has limited the degree to which bodies have been able to collaborate in focussing their efforts to work towards common targets.

The AMC recognises the significant government investment in health workforce planning and reform to date, but calls for clarity about the governance and implementation of these functions into the future.

The AMC understands that, as an accreditation council, it plays a key role in meeting these workforce objectives by accrediting programs that graduate medical practitioners who will meet community needs, by facilitating innovation and reform through its accreditation processes, and by responsive processes for assessing international medical graduates.

The AMC response to meeting these objectives and principles also entails responding to government policy developments and enquiries, including contributing members to expert committees, and working closely with education providers, the medical profession, the Medical Board of Australia and jurisdictions.

The accreditation councils sit in a unique position within the Scheme, allowing them close and ongoing dialogue with professions and educators. From its accreditation assessments, the AMC is able to identify issues such as mismatches among training program curricula, educational outcomes and community need, barriers to completion of training, and system-wide issues that are impacting on education and training. An example is the AMC's work in 2010 to articulate its understanding of the terms competence, competency and competence-based training, and the need to retain for medical education the coarse-grained concept of competent professional practice, where observed performance is more than the sum of the set of competencies. Through this work, the AMC also outlined a framework to guide its accreditation of medical programs and its assessment of international medical graduates. More recently it has begun planning a workshop to consider the topic of generalism and chronic diseases management, to consider the barriers, including training barriers, and disincentives to medical practitioner becoming generalists, with the aim of improving the interface between primary and secondary care to better care for people with complex medical problems.

In this capacity accreditation councils act as a technically informed and connected conduit for information, and thereby contribute to innovation in the professions. If there were a more formalised process under the NRAS for consulting relevant bodies and determining workforce reform priorities, it would be possible to enhance or formalise the role played by accreditation councils.

A key role of the AMC, and the other accrediting councils, is the development of accreditation standards, which the National Law defines as "a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to
practise the profession in Australia.” The AMC sets high level standards that enable and facilitate diversity of approaches and innovation by education providers, and do not prescribe any particular educational model, or details such as staff:student ratios or curriculum hours. That medical schools have been accredited by the AMC for the last 28 years, and in that time medical education has changed so significantly and the number of medical schools and medical students doubled, demonstrates that the accreditation standards enable innovation.

The consultation paper indicates that national boards have noted the opportunities for their leadership to support and drive innovation, including by supporting expanded scopes of practice, multidisciplinary teams and inter-professional learning. The AMC is concerned about the potential blurring of the regulatory roles and profession advocacy roles. The AMC sees that the bodies that set professional standards have important but limited expertise for these tasks. While they do have expertise to develop, with stakeholder engagement, appropriate professional standards and guidelines that enable innovation, the AMC questions whether the regulatory body for a profession should advocate for expanded scope of practice for the profession. As indicated elsewhere, it considers there needs to be an evidence based approach to workforce reform with employers and all governments involved. The AMC observes that the Medical Board of Australia acts as a regulator rather than an advocate for the medical profession. The AMC considers this appropriate.

Cooperation with education providers
The AMC also works very closely with education providers.

The AMC engages peak bodies for the education providers as key stakeholders in any reviews of accreditation standards. The AMC has regular briefings with Medical Deans Australia and New Zealand, and attends the regular meetings of the Committee of Presidents of Medical Colleges. Since 2013, when it implemented a national framework for internship on behalf of the Medical Board of Australia, the AMC has also established more regular interactions with the intern training accreditation bodies, and the Confederation of Postgraduate Medical Education Councils.

This dialogue is extremely valuable for mutual understanding of emerging education and accreditation priorities. This allows medical schools and specialist medical colleges to be proactive in addressing particular evolving social and health sector issues, and bringing the issues to attention of the AMC, so that they are reflected in the standards where appropriate. An example of this working is the Medical Deans request to the AMC, in 2005, to increase the focus on Indigenous health and the support of Indigenous staff and students, which preceded the introduction of specific standards. This partnership resulted in strong support for quite focussed standards in this specific area, and for success in this area. A similar request from the Committee of Presidents of Medical Colleges and the Australian Indigenous Doctors Association in 2012 is leading to the development of specific standards for the accreditation of specialist medical training programs.

This dialogue also allows the AMC to respond to changes in accreditation approaches and health regulation with support from the profession. For example, in its 2012 review of the medical school accreditation standards the AMC developed accreditation standards concerning fitness to practice. These require medical schools to have policies and procedures for managing medical students whose impairment raises concerns about their fitness to practise medicine; and for identifying and supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or ability to interact with patients. These standards address the potential differences between the education provider’s focus on the student experience including students meeting the academic requirements for
completion of their program, and the need for health profession graduates to be fit to practise the profession.

**Cross-professional cooperation**

Enhanced cross-professional cooperation, although not specifically mentioned in the Objectives and Guiding Principles of the National Law, has been a particular focus for accreditation councils, through the Health Professions Accreditation Councils’ Forum. The Forum is a coalition of the accreditation councils of the regulated professions which was established in 2007 prior to the roll out of the National Law. The collaborative work of this group has resulted in the development and implementation of key accreditation aspects of the National Scheme including:

- the Quality Framework for Accreditation, which forms the principal reference document for assessment of the work of accreditation councils;
- the 2012 process for review and re-assignment of accreditation functions to accreditation councils; and
- input into an Accreditation Liaison Group, which includes members of the National Boards, the Accreditation Authorities and AHPRA which have developed a number of good practice guides and explanations to accreditation under the National Law.

The Forum also provides opportunities for high-level linking in accreditation functions with a view to cross-profession efficiencies and opportunities, which has included cross-profession work on accreditation standards and two cross-profession workshops on accreditation processes. The work of this group has been important in supporting the general trend towards program and graduate outcome focused standards with competency measures which allow for innovation in education delivery.

There are also specific examples of collaboration between professions. For instance, the AMC and the Australian Dental Council collaborate on the ongoing accreditation of programs in one medical and dental specialty, Oral and Maxillofacial Surgery, which reduces the burden on accredited provider and the two councils, and has led to improvements in the processes of both councils. Similarly, relevant national boards could also come together for certain accreditation assessments or the development and review of standards for better informed and consistent accreditation outcomes.

Effective cross-professional cooperation will require the accreditation council and the national board for each profession in the National Scheme and the members of each of these two groups to work in a collegiate and cooperative manner. It is unlikely to be progressed if the groups continue to function in silos or with limited communication on matters of common interest or concern.

The AMC understands that AHPRA has recently established internal mechanisms at the level of national board chairs to enhance cross profession debate, which is a positive step. These need to be enhanced, with appropriate links with the accreditation councils.

An important issue that could be tackled in the NRAS Review is the fact that accreditation councils are funded for accreditation activities in one profession only. This may limit the capacity to give advice on cross profession matters. For example, the AMC gave extensive, collegial advice to the Australian and New Zealand Podiatry Accreditation Council to assist it to develop standards and procedures for accreditation of programs in the field of podiatric surgery, which is a specialty of podiatry. This work is not financially supported the National Scheme, despite its value to the Scheme.
Assessment of International Medical Graduates

The AMC also makes a substantial contribution to delivering on the National Scheme’s workforce related objectives through its assessment of international medical graduates. The AMC’s work in this area is detailed in response to question 24.

Limitations to the contribution of accreditation to workforce reform

A commonly held misconception is that the accreditation function under the National Law should be used to drive or even enforce workforce reform and that this should be achieved through a cross-profession accreditation regime. The AMC agrees that accreditation can be an important agent for change, but it cannot be the primary driver for large-scale workforce reform. Accreditation processes play an important role in quality assurance and quality improvement, but in the form of an enabler, rather than the primary driver of change. Accreditation is most effective as a long term facilitator of change within a profession, not across professions.

Accreditation of medical education, which has operated in Australia since 1988, has been shown to strengthen transparency, accountability, and drive continual improvement. It does this in part because the standards and the processes have strong input from the profession, and the willing participation of the education providers. For example, in its 2005 review of specialist medical colleges, the ACCC recognised the AMC accreditation process as an effective tool to effect change, with colleges that had completed AMC accreditation better able to demonstrate transparent and accountable processes and policies for trainee selection and curriculum development and assessment. Other examples of where accreditation has helped to shape the workforce within the medical profession include:

- By requiring medical colleges to train specialists not only for their role as medical experts but also for their broader roles in the health system;
- Education providers are required to address the needs of the communities they serve, and to engage those communities in their educational processes, with the AMC also engaging community members in its accreditation and assessment processes;
- The implementation through the AMC medical school accreditation process of Medical Deans Australia and New Zealand indigenous health curriculum framework;
- In specialist medical training, improvements in assessment processes and the matching of assessment to curriculum, thereby improving the progression and completion; and
- Streamlining of assessment processes for international medical graduates seeking both general and specialist registration in Australia.

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

A reconstituted AHWAC or similar body could inform and review the workforce agenda task within the National Scheme. While the AMC understands and supports the desire not to create a new bureaucracy associated with NRAS, there would need to be clear terms of reference

---

4 Australian Competition & Consumer Commission and Australian Health Workforce Officials’ Committee, Report to Australian Health Ministers - Review of Australian specialist medical colleges, July 2005 p. 8 and 17

5 The CanMEDS framework is the best know example of a list of broad roles for medical specialists, e.g. scholar, manager etc.
and good communication. AHWAC would need to be empowered to call on the work of other bodies in order to succeed.

In order to achieve efficient, directed and effective workforce reform, there is a need for a decision-making process with authority over workforce planning and appropriate legislative backing to undertake this task. This must be informed by broad based expert advice. Only with a clear workforce reform agenda can governments, national boards, accreditation councils, education providers and health service providers work together in implementing their interlinked responsibilities towards common objectives. No one player can drive or achieve reform, due to the interdependent roles and responsibilities of the various stakeholders.

Since both registration and accreditation can facilitate or enable workforce reform, but cannot in isolation be primary drivers, there is need for an appropriately constituted body or decision-making framework to provide oversight and lead the workforce reform agenda and also manage cross-professional issues such as task substitution or job re-design.

Underpinning the functioning of a specific body to drive workforce reform, a primary requirement is a better process to engage all relevant parties in the discussion to determine what reforms are required, how they may be achieved, and each party’s contribution.

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?

As noted above, the AMC develops high level accreditation standards that enable and facilitate diversity of approaches and innovation by education providers, and do not prescribe any particular educational model, or details. These standards do not inhibit multidisciplinary education and training approaches since they do not prescribe particular organisational structures, staffing profiles or course structures.

The accreditation standards for entry level medical programs require “The medical program ensures that students work with, and learn from and about other health professionals, including experience working and learning in interprofessional teams.”

Team-based approaches to health service delivery are well established in medicine and health care, for instance in the management of pregnancy/delivery, management of diabetes, management of renal disease, mental health, and the management of cancer patients. The requirements for multidisciplinary approaches are therefore already reflected in the accreditation of medical education. There are models of students from a variety of disciplines learning and working together in community clinics to deliver, under supervision, patient care, and these need to be promoted.

In relation to changes to technology, models of care and changing health needs, the accreditation standards for medical programs require education providers to relate the outcomes of their programs to community need, and to engage stakeholders in program development and evaluation. In responding to this accreditation standard, education providers give evidence of a range of approaches to considering and identifying community need, including community consultation, workforce and graduate surveys, consultation with jurisdictions and health workforce bodies, and the review of developments in the practice of medicine nationally and internationally.
23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

The AMC is concerned about length of training, and has therefore developed a standard (approved by the Medical Board) “The medical program is of sufficient duration to ensure that the defined graduate outcomes can be achieved.”

Under NRAS, accreditation councils do not have specific influence over the level of qualification that may be set by educational institutions for entry to health professions’ programs of study. Accrediting councils have been encouraged to move to graduate outcome focussed standards, which allow education providers to meet the standards in a variety of ways, and to reduce the focus on process standards. The AMC has always set high level standards that permit flexibility and innovation, that respect the academic autonomy of the higher education providers and, partly for this reason, has not set a academic qualification level (e.g. bachelor degree) for entry level medical programs.

The AMC also has not set a qualification level because its accreditation role and expertise relates to ensuring that an entry level medical program produces graduates who are safe and competent to practise the profession not to higher education quality assurance.

The Tertiary Education Quality and Standards Agency Act 2011, which regulates higher education provision, grants universities power to self-accredit their courses of study that lead to a higher education qualification. All Australian entry level medical programs are offered by higher education providers in this category. Universities, through their own course approval mechanisms, also have the power to approve the level of qualification for a program of study.

Because of the good relationships between the AMC, the Medical Deans Australia and New Zealand and individual medical schools there has been good discussion when a medical school or group of medical schools plan significant change to their programs of study, including changes in the level of qualification offered. For example, the University of Melbourne, the first Australian University to introduce a primary medical qualification set at Masters Degree level, gave the AMC advance notice of its plans. When it became clear that other universities may follow suit, the AMC consulted with education providers, professional bodies, student associations, health consumer bodies, jurisdictions, health workforce bodies and higher education regulators on the change and developed a policy paper and guidance to medical schools addressing the issues arising and the changes it would make to its accreditation processes as a result of the developments. The AMC considered that by developing this policy, it provided an opportunity to flag issues of concern to other related regulatory bodies.

It is possible that other factors such as deregulation of university fees and possible increase in student debt may influence course duration. The AMC will continue to assess and accredit medical programs to ensure that graduates of those programs will be fit for practise.

Theme: Assessment of overseas trained practitioners

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?
A specific objective of the National Law is to facilitate the rigorous and responsive assessment of overseas-trained health practitioners and this process is interlinked with the delivery of other National Scheme objectives including:

- protecting the public by ensuring that registered health practitioners are qualified to practise in a competent and ethical manner;
- facilitation of access to health services in accordance with the public interest; and
- enabling the continuous development of a flexible health workforce.

International medical graduates make a substantial contribution to Australia’s health workforce. The AMC, through its examination processes, is a key player in delivering on these objectives for the medical profession. The introduction of national registration has assisted to streamline processes by standardising registration requirements. However the AMC recognises that there is clearly scope for further improvement in the assessment of overseas trained health professionals.

The Competent Authority pathway, implemented in 2007, provides an example of an alternative approach based on the recognition of prior assessment. The AMC and Queensland Health developed this model, which provides streamlined assessment pathways for international applicants where the standard of assessment, training and clinical experience is considered to be comparable with Australia. It has been very successful in attracting large numbers of international medical graduates to Australia whose knowledge and skills have been assessed by competent authorities, and the process has now been streamlined into AHPRA. A total of 9436 applications, drawn from 101 countries of training have been processed since the system was established, with a total of 7612 granted advanced standing towards the AMC certificate, that is eligible for limited/conditional registration. The AMC has awarded a total of 3959 AMC Certificates to applicants who have successfully completed this pathway.

There have been numerous inquiries into the processes for assessment of international medical graduates, the most recent being the 2011 Australian Government House of Representatives enquiry into the processes associated with the assessment of overseas trained doctors and the resultant Lost in the Labyrinth report. This report made in excess of forty recommendations relevant to a range of bodies, including the AMC and the Medical Board of Australia. The AMC, the Medical Board of Australia and AHPRA, and the Committee of Presidents of Medical Colleges worked collaboratively with individual specialist medical colleges to respond to the recommendations, and to improve clarity and transparency of processes.

Since the release of the Lost in the Labyrinth report in 2012, a majority of the substantial recommendations relating to the AMC assessment processes have been implemented:

- the AMC has resolved time delays on access to the clinical examination with the establishment of the National Test Centre and the increased frequency of testing;

---

6 House of Representatives Standing Committee on Health and Ageing
Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors Tabled 19 March 2012
• processes for the assessment of overseas trained specialists and the Competent Authority assessment pathway have been streamlined to remove administrative impediments;
• AMC IT staff have developed and maintain a portal to enable specialist college staff as well as AHPRA staff to access information concerning the primary source verification of medical qualifications for all international medical graduates seeking assessment or registration;
• the AMC has introduced a new scoring system and advanced computer tablet technology for the AMC clinical examination which has significantly improved the reliability of the clinical assessment and the quality of feedback available to candidates; and
• the AMC has implemented sophisticated CCTV technology at the National Test Centre which is being used not only to monitor the quality of the clinical examinations in real time, but also for examiner training purposes and to allow for the review of individual candidate performance in appeal cases against the outcome of the clinical examinations;
• the National Test Centre is now being used by other accreditation councils and education providers.

In addition to these developments, the AMC is exploring options to improve the processes for international medical graduates to track their application status and assessment outcomes through new candidate tracking systems which are expected to be in place from 2015.

While improvements have been achieved, the AMC recognises that further work may be required to ensure consistency between specialist colleges and within some larger colleges in the outcomes of specialist assessment. The AMC understands that the Medical Board of Australia has convened a working party to revise the guidance to specialist medical colleges on specialist international medical graduate assessment.

In relation the Review’s examination of concerns about the cost of applications for overseas trained professionals particularly around the Pre-Employment Structure Clinical Interview (PESCI), the quoted cost of approximately $1,895 for a doctor undertaking a PESCI is the highest charge, and the AMC understands that there is considerable variation in the cost PESCI and that some providers do not charge applicants.

Theme: Governance of the National Scheme

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

The AMC agrees that the appointment of the Chairperson of a National Board should be on the basis of merit and considers that the chair and members of the Medical Board of Australia demonstrate the experience, skills and competencies genuinely required for these appointments. It agrees that appointment should follow a transparent process. Consideration of merit should include an assessment of the adequacy of technical background and support and standing with the profession.

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?
The National Law does give accreditation councils and national boards complementary functions under the National Law. These roles and functions work effectively in professions where good processes have been established. The effectiveness of the division of roles and the relationships under the National Scheme appears to vary between the professions, depending in part on the maturity of the professions’ regulation processes, the extent to which individuals and organisations in the Scheme have experience in related roles and functions, and technical expertise. The work by the accreditation councils, the national boards and AHPRA to develop good practice guidelines when issues arise is contributing to better delineation of roles, with clear expectations about good practice.

Some accreditation councils have experience and expertise that predates the National Scheme. When the NRAS was implemented, the AMC was already operating national processes relating to the accreditation functions:

- Since 1992, it set accreditation standards for medical programs;
- Since 1988, it had accredited new and existing entry level (primary medical degree) programs in Australia and New Zealand under the provisions of the relevant legislation;
- Since 2002, it undertook the accreditation of all existing specialist medical colleges under a voluntary scheme and of training programs in new specialties as a mandatory part of the recognition of the specialty;
- Since 1987, it administered and continued to develop the examination processes for non-specialist international medical graduates;
- Since 1993, it worked with the specialist medical colleges to facilitate the assessment of overseas trained specialists;
- Since 2007, it developed and implemented the model for the recognition of prior assessment and accreditation of entry level qualifications by approved competent authorities outside Australia; and
- Since 2011, it developed and implemented a model for workplace-based assessment of international medical graduates, providing an alternate to the AMC clinical examination.

The AMC had worked closely with the former state and territory medical boards since 1992 when Mutual Recognition was implemented to achieve consistent national approaches to registration and accreditation. These relationships have carried forward into the National Scheme and the AMC considers that the current relationship with the Medical Board of Australia is good. It is supported by open communication and mutual respect.

The turnover of members of the national boards may diminish these relationships in time, unless there continues to be good orientation and induction, active engagement of board members on accreditation activities and effective dialogue between the accreditation councils and their respective boards.

The introduction of the NRAS has changed the way some of the accreditation processes operate. Largely these changes have been positive, but adjustments include:

- An enhanced monitoring function under the National Law. The National Law requires accreditation councils to monitor accredited programs and education providers so the council continues to be satisfied that the program and provider meet the accreditation standards. Although the AMC was monitoring program before the National Scheme, the introduction of statutory requirements has strengthened the requirement. The AMC
continues to use the same mechanism, a structured progress report, but the explicit focus on ongoing review against the standards and making a judgment about whether conditions have been satisfied and therefore standards met is changing the dynamic of accreditation, and has increased the workload of the AMC and education providers. The AMC intends to review these processes as it reviews the accreditation standards.

- Changes to the accreditation of specialist medical training programs. The AMC has assessed and accredited specialist medical education and training and professional development programs since 2002. Until July 2010, colleges participated in this quality assurance and quality improvement process voluntarily. Under the National Law this is a mandatory process, with AMC accreditation of programs of study linked to the decision by the Medical Board of Australia to approve the program for the purposes of registration. The change to a mandated process increases the significance of the process, with the AMC able to take a range of actions if it believes that a program of study and education provider no longer meet an accreditation standard, including imposing conditions or revoking the accreditation of the program of study. The AMC observes that this change has required some adjustments and significant communication.

Under the National Law there has been a significant change in the responsibility for accreditation standards. Since 1992, as the accreditation body for medical education, the AMC has set accreditation standards, in consultation with stakeholders, and following review of national policy developments and international developments in medical education. It bears the cost of these developments, and of the development of policy that feeds into the development of standards, and provides the expertise for this work. Because the AMC develops standards through consultation, they reflect a broad consensus on the requirements for medical education.

Accreditation authorities operating in the National Scheme must comply with the Quality Framework for Accreditation which requires them to develop accreditation standards that:

- meet relevant Australian and international benchmarks;
- are based on the available research and evidence base;
- are developed with stakeholder involvement and wide ranging consultation;
- are regularly reviewed; and
- take account of AHPRA’s ‘Procedures for Development of Accreditation Standards and the National Law’.

The AMC supports these requirements, as setting an appropriate standard for this important work.

Under the National Law the AMC continues to develop the accreditation standards, but these are now approved by the Medical Board of Australia and, in effect are the Board’s standards. While the AMC strongly supports the need for the Medical Board to be involved in the development of accreditation standards for medical programs, it continues to be concerned that the Scheme removes “ownership” of the standards from the body which develops them and which is regarded nationally and internationally as having the expertise for this task.

As medical education has evolved, and the context in which it is delivered has changed, there have been major changes to medical programs in Australia. Recent developments include:
• the introduction of entry level programs at master-degree level (the MD programs);
• major changes in teaching, learning and assessment methods; and
• Australian university medical courses conducted largely off-shore.

As change occurs, the AMC has reviewed accreditation standards and procedures to ensure that they are clear, and remain appropriate for the changing medical education sector. As the owner of the standards, the AMC was able to make minor changes relatively quickly when the need for greater clarity or new standards responding to new circumstances was required. Under the NRAS model the flexibility for rapid change is diminished.

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

The current system provides sufficient oversight of decisions made by accreditation councils.

Early in the Scheme’s operations, accreditation councils worked with national boards and AHPRA to develop a Quality Framework for the Accreditation Function drawing on national and international good practice principles for accreditation. There are four domains which relate to how well accreditation authorities operate (governance, independence, operational management, and stakeholder collaboration) and four relating to specific accreditation functions under the National Law (accreditation standards, processes for accreditation of programs and providers, assessing authorities in other countries, assessing overseas qualified practitioners). In 2012, the AMC and the other accreditation councils which joined the Scheme in 2010 had their performance assessed by their national board against the domains of the Quality Framework through an open review process.

The relevant domain of the Quality Framework requires the accreditation council to apply the approved accreditation standards and have rigorous, fair and consistent processes for accrediting programs of study and their education providers. Under this domain, the Quality Framework further requires accreditation councils to make their accreditation processes publicly available, to follow those processes, to use competent assessors in accreditation processes, to manage conflicts of interest in accreditation processes, and to have complaints, appeals and review processes.

The Quality Framework requires that “The accreditation authority’s governance arrangements provide for input from stakeholders including input from the community, education providers and the profession/s.” The AMC has structured its decision-making processes to ensure that diverse perspectives are reflected. A range of stakeholders across the medical profession, the community, governments and others in the health sector contribute to the AMC’s accreditation functions through membership of the Council, AMC committees, working parties and expert teams.

In 2012, the AMC also commissioned an independent external review of its operations. The first stages included in-depth reviews of the two key areas of work, assessment of international medical graduates and accreditation of programs. These reviews resulted in separate technical reports on these functions. The second stage was the broader review of AMC functions, governance and effectiveness, and was informed by the more detailed technical reports on the accreditation and assessment functions. The AMC has developed a formal response to the review recommendations, which is publicly available, and the AMC Directors monitor progress against the recommendations.
The AMC has a range of additional procedures to ensure that it makes good accreditation decisions and that there is consistency between accreditation assessments, including:

- significant attention to training and support of assessment team Chairs;
- structured templates for teams which guide them, at each step of their assessment of a program of study, to assess the program against the standards;
- an opportunity for the education provider to comment on the factual accuracy of the draft and on any recommendations, conclusions or judgments in the team’s draft report;
- once the accreditation report has been considered by the AMC accreditation committee, the education provider may ask the committee to consider minor changes, such as editorial changes or through the AMC’s formal reconsideration process consider significant change to the report and/or recommendations;
- an opportunity for the education provider and the AMC team members to provide feedback on the process after each accreditation assessment. Significant concerns raised by an education provider results in a review by an experienced assessor who was not part of the process;
- AMC governance structure that allow recommendations to be reviewed at several stages before they become decisions. For example AMC assessment team members are chosen for their expertise and capacity to contribute to the assessment and accreditation of a medical program. They prepare a report presenting their findings against the accreditation standards. The accreditation committee reviews the team’s draft report to ensure it is a balanced assessment, and that the accreditation standards have been applied appropriately. In making an accreditation decision, AMC Directors consider the advice of the relevant accreditation committee, check that AMC policies and processes have been followed, and the decision is within the AMC’s stated accreditation options; and
- Accreditation reports are public documents.

When they make an accreditation decision, the accreditation councils provide their accreditation report to their national board, which may refuse to approve a program. With the Medical Board of Australia, the AMC has uses this requirement as an opportunity for additional feedback on its accreditation reports and the clarity of its decisions. A representative of the AMC accreditation committee presents the reports to the Medical Board.

The AMC supports the development of better oversight across the health professions and contributes to debate with other accreditation bodies and education providers about what constitutes good practice. Through the Health Professions Accreditation Councils Forum, it is participating in:

- development of a feedback tool which could be adopted for all professions, allowing for education providers to evaluate their accreditation assessment process; and
- consideration of a process for engaging experts in accreditation processes from outside the accreditation council in reviews and appeals thereby adding to the independence of these processes.

Recognising that refusal of accreditation is and should be rare in any accreditation process which includes ongoing monitoring of accredited providers and programs, the National Law requirement for process for internal review when accreditation is refused could be expanded to require such processes where accreditation is granted with significant conditions, or alternatively this requirement could be specified in the Quality Framework.
The AMC is aware of concerns by education providers about the costs of external regulation, and the increased costs to them as all accreditation councils in the scheme have moved to introduce fees for accreditations. Accreditation fees charged to education providers contribute towards (but do not cover) the cost of accreditation being:

- costs that relate to the accreditation of specific programs: initial and re-accreditation of a program, monitoring to ensure continued compliance with standards, review of proposals for program changes, and providing advice to the provider; and

- cost of the accreditation system: development of standards, contributing to national and international policy debate and developments, management of the accreditation system, and providing advice to the National Board and AHPRA as required.

The costs of accreditation within a profession and between professions vary. This variation reflects the variable complexity of professions, programs and providers. For example, medical schools may have widely dispersed campuses (including overseas), and multiple entry pathways. Specialist training providers may manage education and training in one specialty or many specialties, solely in Australia or in Australia, New Zealand and other countries. Costs also vary depending on whether the accreditation authority has found a provider and its programs meet the accreditation standards or, as is required under the National Law, has placed conditions on the accreditation to enable the program to meet the standards in a reasonable timeframe. In circumstances where additional monitoring is required, there are additional costs.

The AMC policy has always been that education providers pay the direct cost of their accreditation assessment, essentially the cost of the work of the AMC assessment team including AMC support for that work. What constitutes the accreditation assessment is changing, as the monitoring of providers and programs required by the National Law has increased.

Costs of accreditation assessments have risen primarily as travel costs have increased and medical programs have become more complex with distributed training in multiple locations. The AMC keeps its processes under review, to implement efficiencies and savings in high cost areas, such as travel, and uses small visits, paper reviews and teleconferences where appropriate as alternates to large assessment visits.

The AMC is considering changing its fee policy since the funding available to it from the Scheme and education providers currently does not adequately cover its program accreditation functions. The AMC applies Principle (3)(b) of the National Law guiding principles whereby fees charged should remain reasonable having regard to the efficient and effective functioning of the Scheme. It will review its fees in consultation with the Medical Board and education providers.

Of note, the AMC seeks no fees from the Scheme for the management of its processes for assessment of international medical graduates.

**Theme: Proposed changes to the National Law**

28. The Review seeks comment on the proposed amendments to the National Law.
The AMC has no comments on the specific amendments to the National Law referred to under this question.

Should the Committee require further information the AMC would welcome an opportunity to expand on the comments in this submission.

Mr Ian Frank AM
Chief Executive Officer