



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

Discussion Paper

February 2017

The Discussion Paper

The Independent Reviewer, Professor Michael Woods, has been appointed by the Australian Health Minister's Advisory Council to undertake an Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions.

This Discussion Paper provides background information on the accreditation system and raises issues for consideration and debate during the Review process.



© Australian Health Ministers' Advisory Council February 2017

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968. This document may be downloaded from the COAG Health Council website at:

<http://www.coaghealthcouncil.gov.au/>

Key Review dates

i. Submissions

Interested parties are invited to provide a written submission to this Discussion Paper by addressing any or all of the key questions, and may provide comment on other related matters.

Due date: COB Monday 1 May 2017

Submissions can be made by email to: admin@asreview.org.au

ii. Consultation schedule

Opportunities for further engagement and feedback from interested parties will be provided through a national consultation process with forums scheduled in every State, the Northern Territory and the Australian Capital Territory. You can make a submission without attending a forum. Dates and RSVP details for the forums are published in the Accreditation Systems Review Bulletin 2 (February 2017) available on the Review webpage listed below.

Contacts

For further information please contact: admin@asreview.org.au

Or visit the webpage at:

<http://www.coaghealthcouncil.gov.au/Projects/Accreditation-Systems-Review>

Contents

Executive summary	1
Consolidated list of issues	4
1 The Review.....	8
Background to the Review	8
Related initiatives	9
Review scope	9
Review process	11
2 The health professions accreditation system	12
Objectives of NRAS	12
What is accreditation?	12
Governance within NRAS	15
Linkages.....	17
3 Improving efficiency	18
Previous reviews of system efficiency	18
Accreditation standards	20
Training and readiness of assessment panels.....	25
Funding of the current accreditation system	28
The cost of accreditation	29
Sources of accreditation authority income.....	30
4 Relevance and responsiveness.....	33
Input and outcome-based accreditation standards	34
Health program development and timeliness of assessment	35
Interprofessional education, learning and practice.....	39
Clinical experience and student placements	41
The delivery of work-ready graduates	43
National examinations	44

5	Producing the future health workforce	46
	Independence in regulation.....	46
	Interdependence of accreditation and registration	47
	The independence of accreditation from other stakeholders.....	49
	Governance of accreditation authorities.....	51
	Role of accreditation authorities	54
	Role of the Health Professions Accreditation Councils' Forum	54
	What other governance models might be considered?	55
	Accountability and performance monitoring	61
	Setting health workforce reform priorities.....	62
	Specific governance matters.....	66
	Appendices	71
	Appendix 1: Recommendations related to accreditation functions from the 2014 NRAS Review ..	71
	Appendix 2: Terms of Reference.....	73
	Appendix 3: Health Profession Accreditation Authorities	74
	Appendix 4: <i>Australia's Health Workforce</i> – Accreditation recommendations.....	75
	References	76

Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AHWMC	Australian Health Workforce Ministerial Council
AHPRA	Australian Health Practitioner Regulation Agency
ALG	AHPRA Accreditation Liaison Group
ANAO	Australian National Audit Office
AQF	Australian Qualifications Framework
ASQA	Australian Skills Quality Authority
COAG	Council of Australian Governments
CPD	Continuing Professional Development
HCPC	Health and Care Professions Council
HPACF	Health Professions Accreditation Councils' Forum
HWA	Health Workforce Australia
HWPC	Health Workforce Principal Committee
IPE	Interprofessional education
NRAS	National Registration and Accreditation Scheme
OECD	Organisation for Economic Co-operation and Development
PSA	Professional Standards Authority
TEQSA	Tertiary Education Quality and Standards Agency
VET	Vocational Education and Training

Executive summary



This Discussion Paper is a part of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (the Review). The Discussion Paper contributes to the consultations that the Independent Reviewer will conduct in every jurisdiction in March 2017 and aims to assist interested parties in the preparation of submissions to the Review.

The Review in context

The approach taken to the Review is threefold: to propose improvements to the system within the existing framework; to ensure the relevance and responsiveness of health education; and to ask the broader question of how can education and training, and its accreditation, help create the workforce that Australia needs, both now and in the future.

In relation to each of these issues, the Review takes as one of its points of reference the legislative requirement that the purpose of the accreditation system is to ensure that graduates of approved programs and overseas trained practitioners are suitably qualified and competent to practice in Australia. Accreditation in this context is antecedent to, and inextricably bound together with, practitioner registration.

A second point of reference is that of ensuring the quality and relevance of the education. Two of the six legislated objectives for NRAS refer to facilitating the provision of high quality education and training of health practitioners and to enabling innovation in the education of health practitioners.

Third, the Review is asking the broader question of why do we need an accreditation system, why does government need to be involved, and what is the most constructive role accreditation can play in creating the future health workforce that best serves the needs of the community.

In this regard, the first legislated objective of the National Law focuses on public safety and professional quality. This is a paramount objective throughout the Scheme, including in the execution of accreditation functions. Further, the final objective confirms that the vision for the Scheme as a whole is for the development of a flexible, responsive and sustainable workforce. As this Review will demonstrate, education and training, and its accreditation, can provide the necessary foundation for such a workforce.

In exploring these questions, the Review is taking into account the broader context within which accreditation takes place. This context includes the other health care system organisations that it interacts with, the overriding objectives of government involvement in the education, training, regulation and funding of the health workforce, and the contribution of the workforce to the efficient, effective and equitable operation of the health system as a whole.

The following sections provide a summary of significant matters for consideration and debate over the coming months, with the body of the Discussion Paper providing greater elaboration.

Improving efficiency

The establishment of NRAS merged over ninety different Acts of parliaments into a single National Law which was then promulgated across all states and territories and applies a consistent and common approach to the regulation of health practitioners and to the accreditation functions.

An efficient accreditation system requires sound and fit-for-purpose processes which are designed to: reduce complexity and unnecessary duplication; increase clarity and transparency; and reduce cost within the system. Each step of an accreditation process has direct resource implications for both education providers and accreditation authorities (and indirect cost implications for students, practitioners and consumers). The NRAS accreditation process costs over \$40M per annum. Previous reviews of NRAS have highlighted concerns about both the efficiency and cost effectiveness of current accreditation processes.

A level of commonality in accreditation standards across the professions creates opportunity for efficiency in the assessment of education programs and providers. Preliminary investigation undertaken by this Review indicates that whilst accreditation authorities have commenced a range of initiatives to enable more consistent approaches to accreditation, there remains a high level of variance together with significant duplication. This is most evident in the assessment and monitoring of education programs. Moreover, there is also duplication with accreditation processes of national education regulators and limited transparency in how fees and levies are set.

The Review is seeking feedback from stakeholders on opportunities for improving the efficiency of the various processes involved in the accreditation of programs of study and the providers of those programs.

Relevance and responsiveness

Ensuring the relevance of the health education system is critical in delivering a health workforce that is responsive to the emerging needs of the community. This requires a flexible and adaptive accreditation system which proactively recognises emerging health and social care issues and priorities, and which provides direction to education providers so that curricula appropriately reflects best practice and is evidence based.

Whilst accreditation processes are commonly accepted by education providers as delivering beneficial outcomes through ongoing quality assurance, one of the issues raised in the Review is the time and resources required in the current system which impacts upon the flexibility and responsiveness of education providers to the drivers of change. A greater focus on broader workforce priorities and the outcomes of health education programs, both in professional competency frameworks and accreditation standards, has the potential to streamline accreditation processes and encourage innovation in health workforce reform. This includes consideration of cultivating an interprofessional learning and practice culture; opportunities for high-quality training in future-focused healthcare environments; and support for alternate modalities of education and training such as the use of simulated clinical practice.

An accredited health education program is expected to deliver a graduate who has the required knowledge, clinical skills and attributes to safely practice as a health practitioner (or to enter a defined period of supervised practice prior to general registration) and who has an appropriate foundation for lifelong learning. This Review raises the question of whether this equates to a 'work-ready' graduate, and considers the role of accreditation in determining the need for a national examination or benchmarking of competence for greater consistency in graduate outcomes.

Producing the future health workforce

More broadly, the Review is considering the reforms needed to produce a flexible, responsive and sustainable health workforce that delivers safe and high quality care. As such, it is exploring issues of governance, responsibilities and accountability, as well as consistency and collaboration across professions.

Best practice regulatory regimes separate the policy advice and direction function from the independent regulator or the body which administers the policy. In relation to Australian health workforce arrangements, the powers to accredit the education delivered to health practitioners for purposes of their registration and to assess overseas trained practitioners are pivotal. The setting and review of the accreditation standards, although a regulatory function, can also effectively set policy directions for health education, such as the level of emphasis on interprofessional understandings that better align to emerging service demand and workforce innovation.

Activities performed by accreditation authorities are part of the regulatory framework, and the regulator's governance and accountability arrangements should ensure that all decisions and activities are objective, impartial, consistent, expert and transparent. Meeting these expectations includes addressing both reality and perception as cornerstones of gaining public confidence.

Key questions for the Review are whether the arrangements for these functions adequately reflect the public interest. This includes exploring whether the current governance arrangements for the accreditation function provide an actively managed and regulated system that responds to the NRAS objectives. This includes:

- The independence/interdependence of accreditation and registration functions, including independence from the stakeholders being regulated.
- Consumer involvement to ensure that public interest remains paramount.
- Whether current arrangements are progressing reform in a sufficiently timely and fulsome manner and, if not, whether there needs to be an external driver that is neither a National Board nor accreditation authority.
- How to address the identified need for a robust and formalised approach by which government policy directions are developed and communicated to the parties operating within NRAS.

Additional specific governance matters under review include the roles of specialist colleges and state-based post-graduate medical councils in the accreditation regimes, the assignment and management of the assessment of the skills and capabilities of overseas health practitioners and the appropriate loci for the management of grievances and appeals for decisions made at various points of the system.

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

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

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?
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?

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?
9. Are changes required to current assessment processes to meet outcome-based standards?

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

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?

Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?
15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

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?
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

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?
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?

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?
22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?
23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

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?

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.
26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

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?

Setting health workforce reform priorities

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?
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?
30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:
- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
 - Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

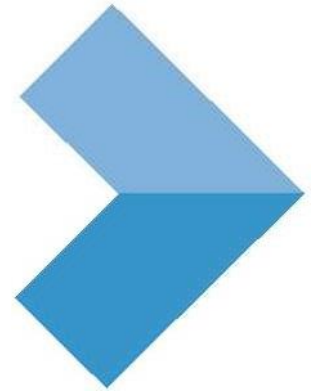
Assessment of overseas health practitioners

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?
33. Is there is 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?
34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?
35. 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?

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?
37. If an external grievance appeal process is to be considered:
 - Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
 - Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

1 The Review



The National Registration and Accreditation Scheme (NRAS/the Scheme) came into operation on 1 July 2010 (18 October 2010 in Western Australia) with national registration commencing for 10 regulated health professions. The Scheme was implemented through enactment of the Health Practitioner Regulation National Law in each state and territory. On 1 July 2012, a further four professions joined the Scheme and it has been announced by the COAG Health Council that a further profession, Paramedics, is also to be included. The establishment of the Scheme followed publication in 2005 of the Productivity Commission report [Australia's Health Workforce](#). The report highlighted the fragmented arrangements for the registration of practitioners and the accreditation of qualifying programs for entry to the professions. The report recommended restructuring and rationalisation, not only to lift standards and provide efficiencies, but also to provide the levers and incentives to drive workforce reform and innovation.

In particular, the Productivity Commission recommended a national cross-profession approach to accreditation, facilitated through the establishment of a single statutory national accreditation entity for all health workforce education and training. The Productivity Commission's view was that this would preserve the best features of the existing arrangements while enabling improvements in workforce flexibility and course accreditation consistency, reductions in compliance costs, and greater opportunities in inter/multi-disciplinary education and training.

When the Scheme was enacted, however, a single national multi-profession accreditation agency was not established. Instead, on transition to the Scheme in 2010, Health Ministers assigned accreditation functions to the existing national councils that were already carrying out these functions on behalf of state and territory registration boards. Following this initial assignment, under the National Law, each of the 14 National Boards has the power to decide whether their accreditation functions are to be exercised by an external accreditation entity or an internal committee established by the Board.

Background to the Review

In 2014, the Australian Health Workforce Ministerial Council (AHWMC) commissioned an independent review of NRAS ([NRAS Review](#)) which made several recommendations that were specific to accreditation (Appendix 1).

In responding to the Final Report of the NRAS Review, Health Ministers accepted in principle its recommendations related to accreditation functions but reported that they were concerned about the high cost, lack of scrutiny, duplication and prescriptive approach to accreditation functions highlighted in the report. The August 2015 [COAG Health Council communiqué](#) stated:

While the recommendations will go some way to improve Australia's accreditation arrangements, Health Ministers believe that more substantive reform of accreditation functions is required to address the issues.

Health Ministers subsequently asked the Australian Health Ministers' Advisory Council (AHMAC) to commission a comprehensive review of accreditation functions. On 10 October 2016, AHMAC released a communiqué which announced the appointment of Professor Michael Woods as Independent Reviewer for the Accreditation Systems Review.

Related initiatives

Concurrent work that is of relevance to accreditation functions under NRAS, and being pursued through other avenues, includes:

- **The NRAS Governance Review** which is exploring improvements to governance, reporting and reform arrangements within the Scheme. Whilst it has determined that governance of accreditation functions is out-of-scope, there is potential for overlap due to interrelationships between accreditation functions, registration functions and the Scheme more generally.
- Implementation of the previous **Review of Medical Intern Training** which examined the current medical internship model and potential reforms to support medical graduate transition into practice and further training. It is noted that Health Workforce Principal Committee (HWPC) is oversighting sequencing of implementation of its recommendations.
- Work commissioned by the **Commonwealth Department of Education and Training on the extent and scope of professional course accreditation practices** to inform the Higher Education Standards Panel on the impact of professional accreditation on Australian higher education and opportunities that may exist to reduce regulatory burden for higher education providers (undertaken by PhilipsKPA).

The Review is cognizant of these initiatives and will endeavour to minimise any duplication and overlap with them.

Review scope

Given the specific Terms of Reference for this Review (Appendix 2) and the context provided by related initiatives, the Review will examine and report on three broad themes.

The Review will examine the costs of the accreditation functions and identify opportunities for streamlining the arrangements, removing unnecessary burdens and complexities, overcoming duplication of activities and data collections carried out by individual accreditation councils and committees and sharing resources, such as in the training of accreditors and related matters. Under this theme, the Review will examine the processes and costs of accreditation processes in the United Kingdom (UK), and will have regard to similar processes in other countries.

The Review will examine the extent to which accreditation standards and processes facilitate flexibility and responsiveness in the development and delivery of educational programs. This includes examining the constraints to beneficial educational innovation in programs including curricula design, clinical training arrangements, use of simulation and interprofessional learning. It will assess the processes and governance arrangements which determine whether the constraints are necessary to ensure the quality and safety of subsequent patient care and other net benefits, or whether the constraints unnecessarily protect custom and practice or the entrenchment of institutional silos.

The Review will examine the establishment of an accreditation system which, together with related components of NRAS (the Ministerial Council, AHPRA, the Agency Management Committee and National Boards) and other relevant parties (consumers, educational institutions, jurisdictions, employers and other accreditation regulators) have aligned incentives to produce a flexible, responsive and sustainable health workforce that delivers safe and high quality care. The assessment will include issues such as governance and reporting, as well as consistency and collaboration across professions.

The final report to AHMAC and Health Ministers will include options for the reform of accreditation systems and structures as well as advice on any necessary legislative changes and policy or administrative actions required to give effect to the preferred option/s and recommendations.

The Terms of Reference focus on the accreditation system within NRAS. However, to make a meaningful contribution to improving the accreditation system, the Review is also taking into account the broader context within which accreditation takes place. This context includes other health care system organisations that it interacts with and the overriding objectives of government involvement in the education, training, regulation and funding of the health workforce. The Review also acknowledges that the workforce operates within the overall health care system which addresses the efficiency, effectiveness and equitable delivery of, health care services to the community.

Limitations to the scope of the review.

The scope of the Review will be limited in the following areas:

- While the Review will focus on arrangements for currently regulated professions under NRAS, it will also be cognisant of the impact on other health professions, noting that the Scheme is dynamic and other professions may progressively be included.
- The Review will not explore in detail specific accreditation decisions. It may, however, refer to examples where they represent either best or poor practice in fulfilling the Scheme's objectives.
- Noting the concurrent NRAS Governance Review, the Review will focus on matters relating to the governance of accreditation functions. In that context, however, it may also include matters relating to functions and powers of National Boards regarding:
 - Where registration standards may impact on education delivery mechanisms and inputs
 - Decisions, processes and governance relating to the assignment of accreditation functions by Boards, and their monitoring and reporting on the delivery of those functions
 - Approaches to articulating health workforce reform priorities for action under NRAS.
- Given other work underway, as outlined above, and the time and resources available to the Reviewer, the Review will consider decisions, processes and governance relating to function assignment, monitoring and reporting across the variety of accreditation arrangements and assessment of overseas practitioners but will not consider in detail:
 - Medical specialist and intern accreditation operations and performance
 - Operational performance in relation to assessing overseas practitioners for either general or specialist registration.

In particular, it is noted that AHMAC is taking steps to implement other recommendations from the initial NRAS Review including those relevant to the assessment of international medical graduates (recommendations 24 and 25).

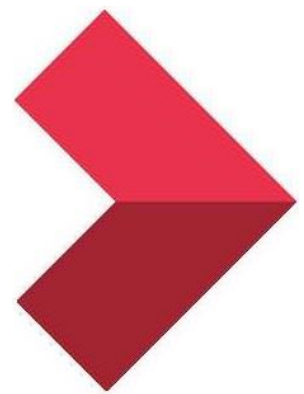
Review process

The Review is underpinned by research and analysis of current evidence and data, and informed by stakeholder feedback through both targeted and broad-based consultation approaches. This initial Discussion Paper seeks stakeholder feedback to questions that identify key issues, concerns or potential options to address the matters set out in the Terms of Reference.

To inform the development of this Discussion Paper, the Review team has:

- Considered previous reports related to NRAS and health workforce regulation matters, including stakeholder submissions to the NRAS Review.
- Undertaken further research and analysis into best practice for accreditation systems and health workforce education and development, both nationally and internationally.
- Developed a communication and consultation strategy and undertaken preliminary engagement with a range of interested parties including representatives from:
 - AHPRA
 - National Boards
 - Accreditation councils and committees
 - Health education providers
 - Health consumers
 - Government departments from all jurisdictions and other agencies (including TEQSA and ASQA)
 - Health service providers
 - Health professional associations.

2 The health professions accreditation system



Objectives of NRAS

The National Law s3(2) identifies six objectives for the Scheme as a whole:

- a. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and*
- b. to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and*
- c. to facilitate the provision of high quality education and training of health practitioners; and*
- d. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and*
- e. to facilitate access to services provided by health practitioners in accordance with the public interest; and*
- f. to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.*

The first objective focuses on public safety and professional quality. This is a paramount objective throughout the Scheme, including in the execution of the accreditation functions. The final objective confirms that the vision for the Scheme is for the development of a flexible, responsive and sustainable workforce and for innovation in education and service delivery. Two other objectives directly relate to accreditation through the provision of high quality education and training of health practitioners and the assessment of overseas-trained practitioners.

What is accreditation?

Academic accreditation

The Australian Qualifications Framework ([AQF](#)) is the policy for regulated qualifications in the Australian education and training system. It underpins the national system of qualifications in Australia encompassing higher education, vocational education and training (VET) and schools.

The AQF provides an integrated national policy that includes AQF qualifications and qualification pathways, the learning outcomes for each AQF level and qualification type, requirements for issuing AQF qualifications, requirements for qualification linkages and student pathways and the alignment of the AQF with international qualifications frameworks.

The AQF also provides the specifications for the application of the AQF in the accreditation and development of qualifications and aims to complement national regulatory and quality assurance arrangements for education and training.

Accreditation of the higher education sector is managed by the Commonwealth Government through the Tertiary Education and Quality Standards Authority (TEQSA) under the [TEQSA Act 2011](#). The Act notes that:

TEQSA registers providers and accredits courses of study. TEQSA regulates higher education using principles relating to regulatory necessity, risk and proportionality, and using a standards-based quality framework.

TEQSA requires providers to comply with the Higher Education Standards Framework ([Threshold Standards](#)) 2015 which outline ‘the minimum acceptable requirements for provision of higher education in or from Australia by higher education providers registered under the TEQSA Act 2011’. The Framework has 7 elements:

- Student participation and attainment
- Learning environment
- Teaching
- Research and research training
- Institutional quality assurance
- Governance and accountability
- Representation, information and information management.

The Act also allows for providers which meet specific criteria to become self-accrediting institutions. This means once the provider meets the registered organisational standards, and is authorised by TEQSA, it can self-accredit its own courses and determine, within the confines of the Australian Quality Framework, the level of the qualification for a program of study and the length of course.

The Australian Skills Quality Authority (ASQA) is the national regulator for the VET system (as defined in s155 of the [National Vocational Education and Training Regulator Act 2011](#)) to ensure courses and training providers meet nationally approved quality standards. There are also state based regulators in Victoria and Western Australia.

The [VET Quality Framework](#) comprises a number of documents that seek to deliver national consistency in the registration and monitoring of Registered Training Organisations (RTOs) and enforcement of VET standards.

National training packages include units of competency and qualifications to meet the training needs of an industry or group of industries. They are developed and validated by Skills Service Organisations in consultation with industry stakeholders, and then endorsed by the Australian Government and state and territory governments for use nationally. A RTO can deliver units of competency and qualifications in training packages if they are within their scope of registration.

VET courses and qualifications included within a training package do not require separate accreditation. However, ASQA can accredit courses in areas without training package coverage against the [Standards for VET Accredited Courses 2012](#) and the AQF.

Health professions accreditation

Professional accreditation is defined by TEQSA as statutory or professional association requirements for the accreditation of courses in higher education by a professional association to enable graduates to practice or be registered to practice in Australia. Accreditation arrangements for professions regulated under NRAS are considered in this category by TEQSA.

In NRAS, the accreditation function is a critical antecedent to registration. As defined in the National Law, there are four principal functions of accreditation and one related advisory function. Part 6, Division 1, s42 of the National Law defines the accreditation function as:

- (a) developing accreditation standards for approval by a National (registration) Board; or*
- (b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards; or*
- (c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia; or*
- (d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession; or*
- (e) making recommendations and giving advice to a National Board about a matter referred to in paragraph (a), (b), (c) or (d).*

Accreditation supports the key objectives of the National Law to provide for the safety of the community through the education and training of a suitably qualified workforce. The impact of the accreditation system in helping shape the workforce to meet the current and future health needs of the community is significant and it is therefore critical that this system is as effective and efficient as possible.

Accreditation authorities develop and review accreditation standards and assess programs of study and education providers against those standards. They determine if the providers are appropriately prepared and are delivering the education programs in line with the accreditation standards. This process commonly involves self-assessment by the education provider, assessment by the accreditation evaluation team including a site visit, and development of a report outlining the accreditation recommendation.

Each accreditation standard refers to a profession-specific competency framework (standards, thresholds or equivalent) which defines the capabilities and outcomes expected of a qualified health practitioner. These frameworks are primarily developed and maintained by the profession.

The health practitioner accreditation system is not unified. Instead it operates as 14 largely autonomous, profession-based entities. A list of accreditation authorities can be found at Appendix 3. With so many entities, the various functions, responsibilities, and relationships across NRAS are often complex and difficult to understand.

The scope and scale of accreditation activities is significant. The AHPRA Accreditation Liaison Group (ALG) has advised that, in 2015-16, the 14 accreditation authorities were responsible for 23 professional streams at a general registration level and 37 specialist streams. This equated to the regular monitoring and reporting of approximately 746 individual programs across Australia, and 338 education providers. This highlights the significant work demands and resource requirements within NRAS, and the associated information preparation and reporting burden for accreditation authorities and education providers.

Accreditation functions involve the threshold assessment and evaluation of education and training courses and institutions to 'guarantee' standards of health professional education and training for an individual's entry into a profession in the first instance. Entry is through registration by one of the 14 National Boards. Section 38(1) of the National Law identifies the five core matters that applicants and registrants need to meet to be registered and to practice a health profession within Australia.

The National Boards are primarily accountable for developing registration standards and codes and guidelines and, in partnership with AHPRA, are responsible for registering health practitioners, and managing notifications against practitioners and monitoring their actions. These processes are largely concerned with regulating health practitioners once they are interacting with the public.

Whilst accreditation authorities undertake accreditation functions, the National Boards have final responsibility for approving accreditation standards and accredited programs of study as providing qualifications for registration in a health profession. Under s51 of the National Law, National Boards may also impose conditions or cancel their approval of programs of study based upon advice from accreditation authorities.

There is further potential interaction between registration and accreditation systems where, as outlined in s38(2) and s52 of the National Law, the National Boards may develop and recommend standards about other issues relevant to the eligibility of individuals for registration in the profession or the suitability of individuals to competently and safely practice the profession. These may include items with an education and training component such as intern training programs, supervised practice and written or oral examinations. However, s38(3) specifies that a registration standard may not be about a matter for which an accreditation standard may provide.

Governance within NRAS

The National Law (s43) specifies that each of the profession-based National Boards must decide whether that authority is an external entity (council) or a committee established by the relevant National Board. One of the primary differences between the two approaches is its operating model, whereby a council is generally an independent not-for-profit registered company, whilst a committee is established by a National Board under NRAS with Secretariat support provided by AHPRA. Eleven of the National Boards have assigned the accreditation functions to an external entity, whilst the National Boards for Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine and Medical Radiation Practice have established committees.

Whilst the accreditation authorities are able to operate independently within NRAS, the National Law specifies that the outcomes of their operations are to be reviewed and approved by the National Boards. In addition, s11(4) notes that the Ministerial Council may give direction to a National Board if, in its opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners.

Accreditation authorities exercise accreditation functions under the National Law as specified in an agreement with AHPRA on behalf of each National Board. They report to their National Board at least twice a year.

Quality Framework for the Accreditation Function

Where external entities (councils) have been assigned the accreditation function, the overarching principles for operation were agreed between AHPRA, the National Boards and accreditation councils and published in an information paper in 2012. This agreement was followed by the [Quality Framework for the Accreditation Function](#) (Quality Framework) in 2013 which advises that it is considered to be the principal reference document for National Boards and AHPRA to assess the work of accreditation authorities.

The Quality Framework states that its underpinning principles are:

- The COAG principles for best practice regulation
- The objectives and guiding principles of the Scheme in the legislation
- The independence of accreditation decision-making within the parameters established by the National Law.

It covers eight domains:

- **Governance:** the accreditation authority effectively governs itself and demonstrates competence and professionalism in the performance of its accreditation role.
- **Independence:** the accreditation authority carries out its accreditation operations independently.
- **Operational management:** the accreditation authority effectively manages its resources to carry out its accreditation function.
- **Accreditation standards:** the accreditation authority develops accreditation standards for the assessment of programs of study and education providers.
- **Processes for accreditation of programs of study and education providers:** the accreditation authority applies the approved accreditation standards and has rigorous, fair and consistent processes for accrediting programs of study and their education providers.
- **Assessing authorities in other countries** (where this function is exercised by the accreditation authority): the accreditation authority has defined its standards and procedures to assess examining and/or accrediting authorities in other countries.
- **Assessing overseas qualified practitioners** (where this function is exercised by the accreditation authority): the authority has processes to assess and/or oversee the assessment of the knowledge, clinical skills and professional attributes of overseas qualified practitioners who are seeking registration in the profession under the National Law, and whose qualifications are not approved qualifications under the National Law for the profession.
- **Stakeholder collaboration:** the accreditation authority works to build stakeholder support and collaborates with other national, international and/or professional accreditation authorities.

Linkages

The accreditation authorities have parallel, overlapping and interconnecting roles with other stakeholders involved in the accreditation process. These include:

- **Governments:** set the overarching strategic direction of the health care system and provide regulation, programs and funding to support the implementation of their policies. Governments can play a key role in setting the purpose and direction of accreditation standards for the broader public good.
- **Education regulators:** the quality assurance agencies for the higher education (TEQSA) and VET systems (ASQA or other state-based authority) are responsible for regulating, monitoring and evaluating the performance of education providers. Through accreditation processes, these organisations assess the quality of education programs and providers.
- **Education providers:** operate in a competitive market to create and deliver health programs that will attract students and meet accreditation standards. In deciding upon the scope and content of the programs, education providers often consult with stakeholders to understand and respond to the needs of their community.
- **Employers:** have a strong interest in the outcomes of education health programs as they require the graduates (their future workforce) to be knowledgeable, safe and capable of working in practice. Many employers also support practical student placements by providing an appropriately supervised learning experience.
- **Professional associations:** represent, and advocate for, their profession, including to ensure that professionals are equipped with current knowledge, clinical skills and professional attributes to maximise their effectiveness in healthcare whilst guaranteeing public safety and quality. Professional associations can collaborate to inform and influence the development and implementation of accreditation standards, including through providing the most current and evidence-based research for the profession.
- **Consumers:** as end-users of the system, have a right and responsibility to participate in the development and execution of the accreditation standards and processes to ensure the future health workforce is flexible and responsive in meeting the evolving needs of the community. This includes providing culturally appropriate care, responding to population and demographic changes and addressing acute and chronic disease care and broader social health issues.

3 Improving efficiency



As affirmed in the National Law, a principle of NRAS is that it operates:

...in a transparent, accountable, efficient, effective and fair way and that fees required to be paid under the Scheme are to be reasonable having regard to the efficient and effective operation of the Scheme.

This requirement for efficiency and effectiveness applies to the National Boards and AHPRA and, through the delegation of the accreditation function, also to accreditation authorities.

In addition, the Quality Framework requires that in setting fee structures accreditation authorities ‘must balance the principles of the National Law with efficient business processes’.

The Productivity Commission [Report on Government Services](#) (2017) defines efficiency and cost effectiveness as:

...how resources (inputs) are used to produce outputs and outcomes, expressed as a ratio of outputs to inputs (technical efficiency), or inputs to outcomes (cost effectiveness).

Cost-effectiveness is further defined as:

...how well inputs are converted into outcomes for individual clients or the community.

Efficient accreditation systems require sound and fit-for-purpose processes which are designed to reduce complexity and unnecessary duplication, increase clarity and transparency and reduce cost within the system. The overall effectiveness of an accreditation system is assessed on its ability to guarantee the quality of its product, be future focussed and responsive to the evolving needs of the health sector and consumers’ needs.

An accreditation system serves as a quality assurance process for education and training systems. In the case of NRAS, the accreditation systems are designed to ensure that the outcomes of the accreditation process result in education and training programs which produce graduates who meet registration standards, are safe and of high quality (with the necessary knowledge, clinical skills and attributes).

This Section explores current accreditation processes, including the development and review of accreditation standards and the assessment process, and discusses opportunities for further improvement to minimise duplication and cost.

Previous reviews of system efficiency

As outlined in Section 1, there have been two significant reviews which have examined the accreditation systems of the registered health professions – the Productivity Commission Report: Australia’s Health Workforce (2005) and the NRAS Review (2014). Both identified areas within the system where there was overlap and duplication resulting in inefficiency and proposed improvements to the cost effectiveness of the system.

Australia's Health Workforce

The review undertaken by the Productivity Commission highlighted inefficiencies in the then accreditation arrangements (for its recommendations see Appendix 4). It drew attention to the inconsistent requirements imposed on educational institutions and trainers by different agencies and proposed a:

...national cross-profession approach to accreditation which would improve cross-profession job redesign and interdisciplinary and multidisciplinary education; improvements to consistency and appropriateness; uniform national standards; and reduced administrative and compliance costs.

NRAS Review

The terms of reference for the NRAS Review included an assessment of the cost effectiveness and efficiency of the current accreditation system. The NRAS Review contracted the Professional Standards Authority (PSA), an independent body accountable to the UK Parliament, working in collaboration with the Centre for Health Service Economics and Organisation, to review the cost-effectiveness and efficiency of NRAS. This work was undertaken between July - October 2014 and was based largely on the financial year figures for 2013/14. The key findings in the report included:

The National Scheme has an annual operating cost of \$214,117,803. This amount includes the expenditure of the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA), the Accreditation Authorities, and the notifications arrangements in New South Wales.

The average unit cost for the operation of the National Boards is \$346 per registrant: when analysed by profession this varies between \$162 and \$1,792. The unit cost per registrant in the UK (estimated at \$301.50) is slightly lower than in Australia.

The Australian approach is different from UK arrangements, where the quality assurance of higher education courses is undertaken by the regulator funded from the registration fee and there is no direct charge to the education provider. The total expenditure on accreditation represents 19.4% of total NRAS expenditure and 6% of UK expenditure.

As a proportion of total spending, the accreditation function in Australia is markedly more expensive than the quality assurance of higher education in the UK. It costs almost three times per registrant when the full cost of accreditation is recognised. This is because a large share of the cost of accreditation is borne by the higher education sector. The cost difference in accreditation between Australia and the UK on a per registrant basis is valued at \$30.2 million.

The PSA report noted the variability amongst accreditation authorities, which included different fee structures, fee-setting methods and extensive duplication of processes (especially in relation to the accreditation of education providers). The report noted that the relative expense of the accreditation function was greater than in the UK and that accreditation fees were increasing. It is important to recognise that, as outlined in the NRAS Review, the PSA was clear to note that firm conclusions could not be drawn and:

...a much more detailed analysis of the differences of performance, process and approach within and between them would be required.

The NRAS Review recommended a series of measures including further investigation into the UK accreditation system to address the cost of accreditation and enable greater consistency and transparency in accreditation processes across the 14 registered professions (Appendix 3).

Accreditation standards

Development of standards

As each of the 14 accreditation authorities is independently responsible for the development of accreditation standards for their respective profession, over time this has resulted in the promulgation of standards that vary across structure, content and terminology.

This variance and the profession-specific nature of the standards has had a significant resource impact upon education providers. The lack of consistency in the development of standards creates unnecessary costs through overlap and duplication. Greater commonality across the professions has the potential to improve outcomes and create resource, time and cost efficiencies.

Additional gains include greater consistency in data collection and sharing amongst the accrediting authorities. This could increase the rigour of the monitoring process and provide a data set which facilitates the identification of trends and future planning. There could also be efficiencies created in the assessment process and the training and skills required for assessing teams.

The lack of commonality and consistency may also be undermining broader system level opportunities to deliver integrated patient centred care (such as multidisciplinary teams) which link health, community and social services. Commonality does not limit the inclusion of necessary discipline-specific references and other information tailored to the requirements of the profession and program. This has been demonstrated in the standards developed by the three accreditation committees (representing quite diverse professions), supported by their AHPRA secretariat.

Opportunities for improving consistency have been considered by other entities. In 2011, as part of a broader higher education reform agenda, the Australian Learning and Teaching Council developed [Threshold Learning Outcomes \(TLOs\) for Health, Medicine and Veterinary Science](#) to align with the Australian Government's standards based quality assurance framework. The TLOs are a consistent framework across disciplines to outline the learning outcomes required from a program of study, and promote the combination of skills, knowledge and professional capabilities that a graduate would be expected to demonstrate from a specified program. This project mapped individual discipline accreditation standards against the TLOs to demonstrate cross-disciplinary alignment.

The potential for shared standards has been demonstrated by the Health and Care Professions Council (HCPC) in the UK. The HCPC has one set of uniformly presented standards for education providers covering 16 professions and common standards for the requirements for registrants. Each profession has standards of proficiency which include both common standards applicable for all the HCPC professions and profession-specific standards.

In this context, AHPRA, in accordance with s25 of the National Law, has developed [Procedures for the development of accreditation standards](#) (2014) which provides guidance to accreditation authorities on the objectives and guiding principles of the National Law, consultation requirements, consideration of international best practice and compliance with the [COAG Principles for Best Practice Regulation](#).

Accreditation authorities, AHPRA and National Boards have agreed on a Quality Framework which states that the standards must be 'reviewed regularly'. The development and review of standards is currently a lengthy and resource intensive process involving multiple rounds of consultation and drafting which consumes significant resources. Accreditation councils have advised that the review process is not necessarily less onerous than the development of the standards themselves. While appropriate consultation is an essential element of sound processes, opportunities to improve the efficiency of standards reviews should be pursued.

It is evident from initiatives underway that there is goodwill from accreditation authorities to better align standards and increase consistency and efficiency in their approach. However, goodwill is not always sufficient and changes to incentives and governance may be required to standardise templates, terminology, timelines and requirements to reduce unnecessary burdens, streamline accreditation processes and generate the sought-after gains in efficiency and effectiveness.

Program and provider assessments

Whilst the specific requirements and details of accreditation assessments vary across professions, the key steps of an accreditation process are largely consistent. These include:

- Development of an application for accreditation and self-assessment by the education provider
- Consideration of the application by the accreditation authority
- A site visit by an accreditation team to the education provider
- Development of an accreditation report, including accreditation decision (which may include conditions) and submission to the National Board
- Consideration of the decision by the National Board (the National Board can approve, refuse to approve or approve subject to conditions the accredited program of study)
- Annual reporting by the education provider to the accreditation authority which may include information such as student enrolment data, clinical placement information, notification of any major changes to curriculum, program outcomes etc.

Given this level of consistency, there may be opportunities to improve the efficiency of the processes through greater collaboration across accreditation authorities.

The Quality Framework serves as the key reference document for National Boards and AHPRA to assess the work of accreditation authorities. It notes that:

...the aim of the accreditation process is not just quality assurance, but also to support continuous quality improvement of professional education and training in order to respond to evolving community need and professional practice.

It is envisaged that the Quality Framework is used by National Boards and AHPRA in assessment of accreditation authority work plans. However, it is not clear if the Quality Framework has been used to highlight specific areas for improvement for individual accreditation authorities.

The Health Professions Accreditation Councils' Forum (HPACF) has also developed [High Level Accreditation Principles](#) (2016) to facilitate a common and collaborative approach to accreditation. The twelve key principles include working collaboratively, benchmarking against international standards and encouraging improvement and innovation, and have been agreed by all councils. However, compliance is voluntary and based on each council's self-assessment.

More generally, the [Joint Statement of Principles for Professional Accreditation](#) (2016) released by Universities Australia and Professions Australia provides guidance for the professional accreditation of university courses. The principles have been designed to be widely applicable and inclusive with the aim of creating national consistency and ensuring processes are transparent, accountable, efficient, effective and fair. It creates a point of reference and negotiation for accreditation processes, outlining respective roles and responsibilities for an evidence based collaborative approach. A range of professions outside of health, including accounting, engineering and computing, also use these principles. These principles were released in March 2016 and create a basis for measuring future impact on consistency, efficiency and effectiveness in accreditation processes.

The Harmonisation Project

In 2014, the [Harmonisation project](#) led by O’Keefe and Henderson aimed to:

...work with higher education institutions and healthcare professional accreditation agencies to identify and match the goals and expectations of education, professional and government institutions.

The project sought to create common assessment principles that through achievement of the TLOs would simultaneously demonstrate compliance with accreditation, registration and higher education quality assurance requirements, thus potentially minimising the burden and cost of accreditation processes in practice. The project outcomes included:

- A national dialogue on articulating and assessing learning outcomes.
- Active disciplinary engagement with the production of a draft statement of common assessment principles.
- A framework of common assessment principles for incorporating professional accreditation and Australian Qualifications Framework standards into assessment mapping in health disciplines.
- A guide to support implementation of the framework.

Further project extensions in [2014](#) and [2015](#) sought to pilot the Harmonisation Project Framework and progress the interprofessional learning agenda for curriculum development and renewal, as will be outlined in Section 4.

Issues

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

Alignment with TEQSA

The terms of reference for this Review included exploring avenues to reduce the duplication and overlap between accrediting authorities and education regulators. Duplication can arise in both the content of accreditation standards and the processes adopted to assess programs and providers against them. The accreditation committees and councils appear to have different approaches to considering and incorporating the relevant standards and assessment processes of TEQSA and ASQA. Accreditation committees refer to the education quality frameworks within their accreditation standards. For example:

Medical Radiation: Standard 2.2 Financial viability and sustainability: The education provider has the financial resources and financial management capacity to sustain the delivery of its medical radiation practice program, consistent with the requirements for registration as a higher education provider with TEQSA.

In contrast, some accreditation councils' standards contain no reference to TEQSA (for example Occupational Therapy, Chiropractic and Medicine), whereas others incorporate the role and findings of TEQSA but to a far lesser extent than do the committees. For example:

- **Pharmacy:** notes that: 'every effort has been made during the review of the APC Accreditation Standards to assure consistency with the TEQSA Standards' and requires under standard one that the education provider is registered as an Australian University.
- **Nursing:** Registered Nursing standards require current registration by TEQSA as an Australian University

The HPACF has noted in their submission to the Commonwealth Department of Education and Training review of professional accreditation undertaken by PhillipsKPA (2016) that all councils:

....are considering the way the new Higher Education Standards are structured and expressed, with the aim of ensuring that their standards align with the flexibility the Higher Education Standards Panel is aiming to support in higher education while recognising the difference in focus in the processes.

Examples of overlap between health professional standards and the education quality frameworks are evident across several domains, but most commonly within domains relating to Institutional Quality Assurance, Governance and Accountability. Utilising the education regulators' assessments of education providers within the accreditation standards, and removing duplicative elements could diminish overlap, improve efficiency and provide another area of commonality across professions.

Issues

2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

The cycle of assessing programs and providers

The current accreditation process includes the evaluation of education providers and programs of study, assignment of an accreditation period (usually for a fixed term), re-accreditation at routine intervals and a monitoring process. Accreditation authorities have distinct and separate processes for accreditation which can vary in cost, presentation, level of evidence required, mode of submission, assessment process and timeframe, and the make-up and training of the assessment team. This diversity is also evident in re-accreditation and monitoring requirements.

In addition to the accreditation of new programs, the National Law s50(1) specifies that accreditation authorities are required to monitor approved programs of study to ensure the authority continues to be satisfied that the programs and providers meet an approved accreditation standard for the health profession. The National Law does not, however, require accreditation authorities to undertake regular cyclical review.

Most accreditation councils have adopted the practice of undertaking a cyclical 'routine' review of an education provider's health programs every five years, with Dental and Optometry reviewing at seven and eight years respectively. The Australian Medical Council has the longest potential accreditation period of up to 10 years without undertaking a full re-accreditation process (six years as standard, with a four-year extension). The length of time before re-accreditation occurs, and whether it occurs as a standard process, appears dependent upon the accrediting authority's approach to risk-based assessment.

Risk management approaches

A risk management approach places the focus on outcomes and the reduction of harm, whilst considering the most efficient and effective mechanisms to achieve and monitor performance and respond to priorities as they arise. The approach requires processes to be appropriate and proportionate to the level of risk, and responsive to the likelihood and consequence of potential harms. They also direct the resources of the organisation to where they are best used, and reduce the burden of assessment for well-performing organisations. A risk based approach can introduce efficiencies through agreeing core common processes across professions and with the education regulators and specifying the key data requirements for accreditation and monitoring.

TEQSA uses a [Risk Assessment Framework](#) with an overall focus on risk to the student or institution. The scope of assessment and the education provider's evidence requirements are tailored to the risk profile and track record of each provider.

ASQA has a similar approach and utilises a risk-based approach to regulation that is consistent with the [Australian Government Guide to Regulation](#). ASQA identifies two types of risk - systemic risk and provider risk - and responds according to its [Regulatory Risk Framework](#) which places a focus on the most significant risk. This includes working with other regulatory, funding and policy bodies to treat risks beyond ASQA's jurisdiction that may undermine confidence in the sector or in ASQA's ability to regulate effectively.

HCPC in the UK also uses a risk management approach to monitoring and review. Within NRAS, the three accreditation committees adopt the same approach used by the HCPC which is noted in the Frequently Asked Questions section on each of the committees' websites:

The Accreditation Committee does not accredit programs for a set period. Instead, a program only continues to be accredited if the Accreditation Committee continues to be satisfied that the program and provider continue to meet the accreditation standards.

The Review understands that other health practitioner accreditation authorities are gradually moving to risk-based assessment processes. However, the approach to risk based accreditation is not explicit amongst accreditation councils and there is variation within the standards on the extent to which it has been incorporated. The HPACF in its submission to the Commonwealth Department of Education and Training review of professional accreditation undertaken by PhillipsKPA (2016) identified that:

Forum members recognise the need to balance the requirement that they monitor providers to ensure they continue to meet standards with a risk based approach to accreditation. A number of accreditation authorities are exploring or implementing measures to enhance their monitoring of high risk providers and programs and streamline processes for providers and programs that are low risk. The latter may entail focussing an assessment on specific issues, or varying the format of accreditation in recognition that a comprehensive site visit is not essential.

The rationale for the different approaches to cyclical assessment appears to be historical. As noted, whilst there are efforts to further streamline assessment processes and focus on risk management approaches to re-accreditation and monitoring, no explicit timeframes or requirements have been established which apply to all accreditation authorities.

There are also variances across the accreditation authorities in the format, language, content requirements and timeframes required as part of monitoring and reporting. The information requested is not the same and the layout, language and different levels of detail amplify these differences and suggest potential ways of improving system level efficiency. Formalising and increasing the sharing of resources and information and harmonising documentation requirements could be a useful first step to streamline assessment processes and reduce duplication of effort for both the education providers and the accrediting authorities.

Issues

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

Training and readiness of assessment panels

The assessment process is undertaken by a team selected by the accreditation authority to complete an analysis of the health program against its standards. The Quality Framework specifies that:

...accreditation authorities are required to have policies on the selection, appointment, training and performance review of assessment team members that provide for the use of competent persons who are qualified by their skills, knowledge and experience to assess professional programs of study and their providers against the accreditation standards.

Whilst specific practices vary across accreditation authorities, all have guidelines on the selection of team members for assessment panels. It generally depends upon the features and characteristics of the program and provider to be assessed, with a process of matching expertise to those requirements. It is noted that review teams often vary in size depending on the size of the provider and program, and the geographic location/s of the program.

During the preliminary consultation, issues raised by education providers regarding the assessment panels included:

- A lack of understanding of existing processes and policies implemented by education provider regulators (TEQSA and ASQA) resulting in considerable duplication.
- A lack of consistency in the documentation required by assessment teams from the same authority as well as across professions.
- The recommendation of changes to the health program that were considered beyond the purview of the accreditation standards.

Given the administrative requirements associated with accreditation, variance in the consistency, due process or experience of assessment teams can impact on the efficiency of the process.

Results from a survey undertaken by HPACF in 2012 showed that accreditation councils differed in relation to whether they included anyone external to the council or to the profession in their review team. Of those councils with external members, these were most commonly academic staff or members of other professions. To a lesser extent, councils may include a health consumer or experienced health services management member or jurisdictional government representative (as in the case of accreditation of medical specialist training positions). The survey also showed that approximately one-third of the accreditation councils had professional staff in their teams who contribute to ensuring a common standard of assessment across accreditations.

The HPACF has also identified examples in existing accreditation processes that not only improve efficiency but also support interprofessional practice, including sharing accreditation team members, allowing observers on other health professional teams, joint training and sharing of procedural manuals.

Remuneration of panel members

Payment to assessment teams varies with some authorities aligning payment with the Remuneration Tribunal (an independent statutory body that handles the remuneration of key Commonwealth officers) and others establishing their own rates. Some authorities appear to have in place lump sum arrangements whilst others base payment on the number of days worked. Initial analysis from publicly available material by the Review confirms different rates for the Chair and members of assessment teams.

Other models of assessment panel formation

TEQSA has a 'Register of Experts' who are expected to have and maintain significant knowledge and experience in one or more identified areas of expertise. The process, remuneration, expectations and training are outlined on the [TEQSA website](#). The daily rate paid to Experts is \$621 (ex GST), which aligns with similar determinations made by the Remuneration Tribunal. TEQSA pays for experts' reasonable costs associated with approved travel, including accommodation, food and incidentals, as required. Additional administrative costs are included in the daily rate of payment.

Experts have access to an instructional video and tip sheet, and feedback is sought from them in relation to additional training needs.

In the UK, the HCPC uses what it calls 'Partners'. Partners' roles include Continuing Professional Development (CPD) assessors, legal assessors, panel chairs, panel members, registration assessors and visitors. The aim is to provide the expertise the HCPC needs for decision-making and ensure that there is professional, and lay (public) input into its functions. Visitors are recruited for its accreditation (or approval) process. As described on its website, Visitors:

...include registered members of the professions that we regulate and members of the public. They assess HCPC accredited education and training programmes to decide whether they meet our standards. Visitors visit education providers and report back to the Education and Training Committee when it makes decisions about programme approvals. They also give expert advice and contribute to decision making as directed by the Council or relevant committee.

Each assessment panel includes a member from the specific profession and a lay member. In addition to meeting the stated experience and knowledge requirements, all Visitors receive common comprehensive training for the role. As previously noted, the conditions, fee and expenses for Partners are uniform and clearly stated.

The HCPC also has common standards, guidelines, systems and processes for all 16 professions. These in turn require a smaller staffing component and allow for common conditions and training. The use of Partners, who are contracted for specific roles and timeframes, also reduces the overall cost to the system.

Whilst HPACF has welcomed greater interprofessional cooperation between councils, this has not yet led to many Australian examples of shared, common or consistent processes which could reduce the level of variation and impost that it has on the education providers. At issue is how rapidly and to what extent the accrediting authorities are able and prepared to harmonise, or develop common processes. Other opportunities such as shared assessor training, common identification and use of health profession experts, and potentially co-assessment of education providers and programs, may help raise standards and support efforts towards greater interprofessional learning.

Issues

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

Funding of the current accreditation system

In addition to the requirement for efficiency as stated in the National Law, another principle contained within the [Intergovernmental Agreement](#) for NRAS is that the Scheme is to be self-funding in the long term:

12.3 The Parties will meet the initial costs of establishing the national registration and accreditation Scheme, but it is intended that in the longer term the Scheme will be self-funding.

This means that the costs of the activities required under the National Law must be covered through charges to stakeholders. However, there is no clearly stated description of what this means: how NRAS is to be funded; by whom; at what level and through what principles; and how the income earned by the Scheme is to be allocated amongst the different entities such as National Boards, accreditation authorities and AHPRA.

If the principle is that the beneficiaries of a system should pay for it, in the accreditation system the beneficiaries include:

- Education providers delivering the programs of study, through attracting income from students wanting to achieve registration as a health professional and from the Commonwealth for supported student places.
- Students (as fees), through being able to undertake accredited programs of study which can lead to employment.
- Registered practitioners (as registration fees), through the protection of the reputation of the profession.
- Health consumers (as taxes, paying education providers for supported places), through receiving publicly subsidised health services from well-educated and trained health practitioners.

The current approach is that registration fees are used to varying degrees across professions to contribute to accreditation costs. Whilst Health Ministers receive advice from AHPRA on the registration fees charged by respective National Boards, this advice does not include any information on the underlying costs of regulation (such as the proportion of registration fees being allocated to accreditation authorities). Similarly, accreditation councils, as independent entities, are not required to disclose their process for setting accreditation fees and levies.

There is no cross-subsidisation of professions between the 14 National Boards or between the 11 accreditation councils. Thus, each accreditation council is expected to generate adequate income to sustain its accreditation and assessment processes. Data provided to the Review indicates a mix of surpluses and deficits across the accreditation councils for the accreditation functions.

As the Review does not have access to the full accounts for councils it cannot comment on the existing income streams and financial practices used by them. The three accreditation committees report that they exactly balance income and expenditure and this is assumed to be due to income and funding being directly controlled and allocated by the relevant National Board and AHPRA (and managed within the total income stream provided to those Boards). As part of the consultation process, the Review will seek additional financial data from the HPACF and all accreditation authorities to better understand income streams and the unit cost of accreditation processes.

The cost of accreditation

As noted earlier, the NRAS Review engaged the PSA to undertake a comprehensive analysis of the cost effectiveness and efficiency of the National Scheme. Some of the costing analysis and interpretations contained within the NRAS Review Report were challenged by the National Boards and accreditation councils. They considered that the data was incomplete and that some costs were a result of the newness of NRAS and included establishment costs.

NRAS Review findings

The NRAS Review findings and recommendations concluded that the Australian system was relatively expensive and that there was evidence of increasing costs including fees charged to providers. The PSA found that accreditation within NRAS was ‘almost three times more expensive when compared on a per-registrant basis, than the quality assurance of higher education programs of study by regulators in the UK’ and the percentage of regulatory expenditure spent on accreditation in Australia was calculated at 19.4% in comparison to 6% in the UK. The PSA suggested that having 11 separate councils was likely to ‘be an inherently more expensive arrangement for the delivery of this function’. In addition, there was a concern that due to the accreditation authorities having a monopoly on accreditation process, the continued lack of scrutiny could diminish any incentive to improve efficiency and cost effectiveness.

This Review has received a paper ‘Cost of Accreditation in the National Registration and Accreditation Scheme’ (the Costing Paper) prepared by the ALG. This paper is both a response to the PSA costing used within the NRAS Review and a detailed presentation and explanation by the accreditation authorities of the current costs of accreditation.

The comparison with the UK system, which included the HCPC and seven individual accreditation bodies, and interpretation of the cost data, is questioned by the ALG. The ALG advises that accreditation fees charged to education providers increased initially with the introduction of NRAS due to multiple factors including higher expectations from a national system and a broader role for accreditation authorities.

The ALG also cites the difference in scope and intent between the two systems such as different legislative frameworks, a narrower range of functions for some of the UK authorities, and the involvement of other (uncosted) bodies undertaking the activities required of the Australian accreditation authorities. The Costing Paper claims that Australian roles, such as facilitating workforce flexibility and education innovation, are outside of the remit of comparable authorities in the UK. The ALG also claims that the respective workforces, funding models, operational process, professional risk profiles, scale and history call into question the validity of the calculations and comparability. However, the Costing Paper does not provide further detail on the cost of these (additional) factors or how they impact on the core accreditation processes.

The ALG has provided data covering income and activity for the period 2013/14 to 2015/16.

	2013/14	2014/15	2015/16
TOTAL INCOME	\$40,656,418	\$42,307,716	\$40,353,706
Accreditation standards developed in the FY	85	9	4
Accreditation standards reviewed in the FY	7	6	4
New programs accredited in the FY	77	90	85
Programs re-accredited in the FY	95	140	97
Programs monitored in the FY	414	472	610
Site visits undertaken in the FY	104	169	91

The financial data in the Costing Paper cannot be directly compared to the PSA work as it covers different time periods when NRAS was in distinctly different stages of maturity and activity. Further, the NRAS Review costing figures were based largely on the financial year figures for 2013/14 and data from the establishment of NRAS, whilst the ALG Costing Paper uses data from 2013/14 until 2015/16.

This Review has also undertaken a preliminary investigation into systems in other countries, including Canada and the USA. However, without a detailed analysis of each element of the accreditation process across jurisdictions (both in Australia and overseas), it is difficult to undertake a direct comparison of the cost of accreditation across international systems. These primarily relate to the differing nature of health practitioner registration schemes and accreditation arrangements, governance within those schemes and intersections with other parts of public administration (such as education portfolios).

Further exploration of accounting methods, accrual versus cash-based financial year figures, definitions of activities, income versus expenditure mapping and definitions in the UK and elsewhere, as comparators for the Australian system, will be progressively worked through with accreditation authorities.

Sources of accreditation authority income

Accreditation authorities receive income from various sources, including:

- National Boards allocating a portion of the registration fees they receive
- The charges made to education providers for accreditation services
- Some accreditation authorities (Medicine, Dental, Pharmacy, Physiotherapy, Chiropractic, Optometry and Occupational Therapy) also source additional income from the assessment of overseas trained practitioners and offshore competent authorities.

Income from registrant fees

National Board funding is primarily made up of registrant fees, with a lesser amount from other sources (e.g. investments). The ALG reports that registration fees made up 88% of AHPRA's total income from transactions in 2015/16. According to the ALG, total AHPRA income and expenses from transactions and total funding contributions to accreditation authorities as reported by AHPRA 2014 – 2016 is as follows:

	2013/14	2014/15	2015/16
Total income	\$167,859,000	\$170,463,000	\$170,929,000
Total expenditure	\$151,887,000	\$168,602,000	\$169,077,000
Total funding contributions to Accreditation Authorities (committees and external)	\$7,438,000	\$11,659,000	\$9,754,000
Funding of Accreditation Authorities for accreditation functions as a % of AHPRA's total income	4.4%	6.8%	5.7%
% of AHPRA's expenditure as funding of Accreditation Authorities for National Law accreditation functions	4.9%	6.9%	5.8%

Funding received from registrants is a significant source of income for accreditation authorities and has risen from 65% to 73% (as a percentage of the combined funding stream) over the same three-year period.

The process for determining the funding amount required from National Boards is via an annual request for funding based on the work plan of respective accreditation authorities. This amount is then agreed with AHPRA and formalised in the annual contractual agreement for the accreditation function.

Income from education providers

The ALG also reports that accreditation authorities collected fees from education providers in the amount of \$4.1 million (2013/14) and \$3.6 million (2015/16) respectively. Education providers receive their revenue from established Commonwealth funding clusters and student contribution bands. It is not known at this stage whether these rates take account of accreditation costs.

There is variance in how education providers are charged for the accreditation of their programs. The Review understands that four accreditation councils charge annual fees to education providers, thus enabling the providers to spread the cost of accreditation over the cycle (as well as providing a recurrent funding stream for accreditation councils). It is understood that one accreditation council also charges a one-off fee for the accreditation of new courses in addition to an annual fee. The Review is seeking additional information on the varied approaches and its impact on education providers.

It is unclear at this stage how the relative sharing of costs between registrant fees and fees charged to education providers associated with the accreditation of an education program is established. The Review is seeking access to information as to how those funding bids are developed and agreed. This may assist the analysis of how the fees charged for accreditation services to education providers are

determined and balanced against the respective contributions made from registrant fees and any assumptions made about cross subsidisation from other income sources. The Review is exploring the feasibility and requirement for a policy framework/guideline to assign fees and levies for funding the accreditation functions under NRAS.

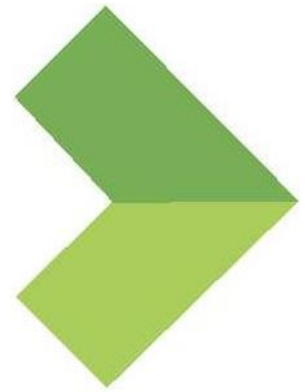
Income from the assessment of overseas trained practitioners and offshore competent authorities

The assessment of overseas qualified practitioners and the assessment of offshore education programs also provide sources of income to some accreditation authorities. The Review understands that other income generating activities (such as qualification and skills assessments for the purposes of immigration) are also undertaken by these independently constituted bodies. However, unlike funding from National Boards (which is a more stable source of income), income from the assessment of overseas health practitioners can vary and is dependent in part on whether the profession remains a priority for the purposes of skilled migration. The Review is seeking to examine the extent to which there is cross subsidisation between each component of the accreditation functions within the individual authorities (e.g. using funds from international qualification assessment fees to support other accreditation functions).

Issues

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?
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 onshore programs?

4 Relevance and responsiveness



Accreditation advances the health education system through a process that guides the continual quality improvement of programs and curricula to reflect current and future priorities and best-practice. Whilst there is no debate on the importance of accreditation, any issues with the development and content of accreditation standards and their application can place significant burdens upon education provider resources and impact their responsiveness to professional workforce priorities. This Section explores the opportunities and constraints created by the existing accreditation system in the development and delivery of health education programs.

Consumers expect that health practitioners will respond to changing needs and that education programs keep up with these changes, creating competent and skilled graduates who are ready to work in new and evolving healthcare environments. Education providers, however, need to respond to many stakeholders, including students and employers as well as the regulatory authorities who set the accreditation and registration standards and profession-specific capability frameworks.

Three of the six objectives of NRAS relate directly to health professional education and training, with one of them also addressing the broader issue of innovation in service delivery (i.e. workforce reform). The relevant objectives include requirements to:

- Provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
- Facilitate the provision of high quality education and training of health practitioners.
- Enable the continuous development of a flexible, responsive and sustainable health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

Accreditation authorities (councils and committees) and their processes have the potential to contribute to the achievement of these objectives by driving innovation in health professional education and responding promptly to workforce reform priorities through a proactive approach towards the development, drafting and implementation of accreditation standards. This includes contributing to the maintenance and currency of the professional capability frameworks.

A significant feature of the Scheme, however, is that the authorities do not have ultimate responsibility for the approval of standards or approval of programs of study as providing qualifications for registration or endorsement – these powers are reserved for the individual profession-based National Boards. The relationship between accreditation authorities and National Boards is assessed in greater depth in Section 5.

Input and outcome-based accreditation standards

Whilst it is recognised that accreditation standards and assessment processes contribute to continuous quality improvement of education programs, it is important to ensure that they do not unnecessarily constrain innovation by education providers or limit the development of a flexible and responsive health workforce. Part of this debate has been the respective benefits and limitations of outcome-based standards compared to standards which specify educational inputs and processes.

The HPACF has collaboratively adopted and/or produced a number of documents which provide guidance to accreditation authorities in the delivery of best practice processes and standards design. For example, the [High-level Accreditation Principles](#) (2016) recommends:

- a right-touch approach that is based upon a proper evaluation of risk, is proportionate and outcome focussed; and,
- the development of accreditation standards that give priority to outcomes and results, and encourage improvement and innovation in education programs.

An outcome or competency-based approach to standards development focuses on monitoring the desired performance characteristics of health graduates and establishes observable and measurable metrics for tasks that demonstrate successful achievement of the identified competencies (Gruppen, 2012).

Most accreditation authorities are either considering, currently developing, or have already implemented accreditation standards that are ‘outcome focused’. This lack of restriction on how the learning outcome is to be achieved provides scope for education providers to develop more flexible and innovative programs of study. Associated with the adoption of an outcomes, a number of accreditation authorities are progressively adopting a risk-management approach to assessment which places the focus on outcomes, whilst continually applying resources to minimize, monitor, and control the probability and/or impact of any problems or issues and respond to priorities as they arise. This requires processes that are appropriate, proportionate and responsive to the level of risk.

Some examples of outcome focussed accreditation standards and statements on competencies include:

Medicine: [Procedures for Assessment and Accreditation of Medical Schools](#) (2015) specifically notes that the Australian Medical Council focuses on the achievement of objectives, maintenance of educational standards, public safety requirements, and expected outputs and outcomes rather than on detailed specification of curriculum content or educational method.

Optometry: [Accreditation Standards and Evidence Guide for Entry-Level Optometry Programs; Part 2 – Standards](#) (2017) recognise contemporary practice in standards development across Australia and internationally, where there is a strong shift away from ‘inputs’ towards patient and learner centred ‘outcomes’.

Dental: [Professional competencies of the newly qualified Dentist](#) (2016) outline the attributes and competencies required by a new graduate. The document notes that although it does not prescribe the curriculum of a training program, providers will need to demonstrate that the learning outcomes address the competencies and that there is a clear relationship between learning outcomes and the student assessment used.

During the preliminary consultations with interested parties, support has been expressed by some stakeholders for the retention of a limited number of input-based standards on the basis that they can provide clear guidance to education providers and ensure at least the minimum achievement of specific tasks. It is also acknowledged that assessment against outcome-based standards is more complex than simple measurement against defined inputs. Some accreditation standards which retain elements of input standards include:

Nursing: [Registered Nurse Accreditation Standards](#) (2012) are predominantly outcome focussed. They state that the standards do not prescribe the content of the curricula, the inclusion of core subjects or the educational approaches required to deliver the study program.

However, the criterion in Standard 3 specifically identifies that the program provider must demonstrate a minimum of 800 hours of workplace experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health-care settings.

Occupational therapy: [Accreditation Standards for Entry-level Occupational Therapy Education Programs December](#) (2013) states in Standard 4.2 that fieldwork/practice education experiences are of sufficient duration to allow integration of theory to practise. The standard references the World Federation of Occupational Therapists' requirements as being a minimum of 1000 hours, including at least one fieldwork placement of up to 8 weeks duration.

Podiatry: [Accreditation Standards for Podiatry Programs for Australia and New Zealand](#) (2015) state that the indicative clinical practice amount per student is a minimum of 1000 hours.

Accreditation standards should be clearly articulated and drafted to reflect current evidence and best practice. If the intent of NRAS is to facilitate the provision of high-quality education, whilst enabling innovation in education and service delivery, the standards need to enable flexibility whilst also ensuring compliance with quality and safety.

Issues

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?
9. Are changes required to current assessment processes to meet outcome-based standards?

Health program development and timeliness of assessment

The large number of health programs being delivered nationally, and the current reliance on cyclical accreditation reporting and processes, reinforce the need for consistency of standards and processes wherever possible and minimisation of unnecessary complexity, time and cost. While issues of efficiency are considered in Section 3, this Section looks particularly at issues relating to the effectiveness of the content of accreditation standards and their application.

The health professions accreditation process seeks to ensure that an education provider is appropriately equipped to deliver a program of study, and that the learning outcomes of the academic program align with the professional competency and capability requirements. As such, an education provider must be responsive to both the accreditation standards and professional competency frameworks.

Professional competency frameworks

Each professional accreditation standard refers to a professional competency framework (standards, thresholds or equivalent) which defines the abilities and outcomes expected of a qualified health practitioner. These documents provide guidance to education providers in the development of the curricula and associated learning outcomes as they must align with the requirements of the competency framework.

Currently, each professional competency framework differs across its domains (or fields or elements) that define a competent health practitioner. For example:

Osteopathy: [Capabilities for Osteopathic Practice](#) (2009) describes six domains across clinical analysis, person oriented care and communication, osteopathic care and scope of practice, primary healthcare responsibilities, interprofessional relationships and behaviour and professional and business activities.

Medicine: The Graduate Outcome Statements within the [Standards for Assessment and Accreditation of Primary Medical Programs](#) (2012) defines four domains that define a competent medical graduate which are Science and Scholarship: the medical graduate as scientist and scholar, Clinical Practice: the medical graduate as practitioner, Health and Society: the medical graduate as a health advocate and Professionalism and Leadership: the medical graduate as a professional and leader.

Physiotherapy: [Physiotherapy practice thresholds in Australia and Aotearoa New Zealand](#) (2015) describe the competence required for initial and continuing registration. They outline the varying roles played by a physiotherapy practitioner (including practitioner, professional and ethical practitioner, communicator, reflective practitioner and self-directed learner, collaborative practitioner, educator and manager/leaders) and describe the key competencies associated with each role.

As noted in Section 3, the [TLOs](#) for Health, Medicine and Veterinary Science (2011) were developed to provide an overarching statement of healthcare professional-entry level outcomes and to define common domains of competence that professional-entry healthcare graduates are expected to demonstrate. During development, the project mapped the TLOs against the existing professional competency frameworks which identified alignment and a logical fit. However, whilst the TLOs are mentioned in some health professional accreditation reference material, there does not appear to be any consistency in approach to further adoption or standardisation.

All professional competency frameworks seem to have the same intent to describe the desired characteristics and competencies of graduates and registered health practitioners. Given the apparent consistency in domains and roles across professions, including communication, ethical behaviours, leadership and collaboration, there is an opportunity to consider the application of the TLOs and commonality more broadly.

Many of the competency frameworks noted that they are regularly reviewed and updated, however the timing of review was less clear. In addition, whilst the involvement of educators, practitioners and regulatory bodies in the development and review process was identified, very few mentioned the involvement of consumers and others (such as employers) who could provide the critical perspectives of community need and broader workforce reform.

Further, it is noted that there is variability across professions regarding the authorship and ownership of the competency frameworks which currently includes the National Boards, accreditation councils and the professional associations themselves. This raises questions about the responsiveness of the health workforce to deliver future health care needs, adopt new roles and deliver integrated services through interprofessional practice, especially if each profession is controlling their scope and practice requirements.

Issues

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?

Education accreditation standards

The health care system responds in various ways to changing care needs, technologies and other drivers. It is important to ensure that this responsiveness is not impacted by bureaucratic processes or unnecessary compliance regimes.

One of the consequences of an accreditation regime is that it introduces time lags into the responsiveness of education and training to the ongoing forces of change. During the preliminary consultation, several education providers drew attention to a lack of consistency across the accreditation standards and associated implementation which impacted upon the timely development and delivery of health programs. Issues raised included:

- The lack of clarity of statements within the standards and certainty of their interpretation by the accreditation teams, including the level of detail required for some items.
- The apparent overlapping and duplicative nature of processes across and within professional disciplines.
- Variance in requirements between self-regulating professions and those under NRAS.

Across professions, there is variance in the length of time taken for the accreditation of a new or substantially changed program of study. For example:

Podiatry: [Accreditation Procedures for Podiatry Programs for Australian and New Zealand](#) (2016) outline that the assessment process for a new or existing program of study needs to begin 24 months prior to the commencement of the program.

Occupational Therapy Council: [Accreditation of Entry-Level Occupational Therapy Education Programs – Guidelines for Education Providers](#) (2015) note that a provider must indicate their intention to commence a new program and ensure they are familiar with accreditation requirement between 12-18 months prior to the start of the program.

The accreditation standards are generally reviewed every five years, and accreditation and re-accreditation processes can take up to 24 months to complete. In addition, any changes to a health program, its delivery mechanisms or its learning outcomes that represent a significant departure from the accredited course structure, are required to be reported to the relevant accreditation council for review and approval at least 12 months before its intended introduction. What determines a significant change is not always clearly defined and there are material differences across professions.

Whilst monitoring and assessing changes are important to maintaining delivery of high-quality programs that meet standards and objectives, they create a further and longer lag before courses are revised and new graduates emerge as registered health practitioners. As noted in Section 3, the Harmonisation Project sought to apply the TLOs across health disciplines and simultaneously demonstrate compliance with accreditation, registration and higher education quality assurance requirements. Deliverables from the Project (including a framework and implementation resources for common assessment principles) provide some guidance that could potentially minimise the burden and time associated with accreditation processes.

As also noted in Section 3, the accreditation standards developed by the three accreditation committees, supported by their AHPRA secretariat, have been designed to align with the standards from the ASQA Quality Framework or the Higher Education Threshold Standards Framework, noting the role played by the respective quality assurance agencies for the VET and higher education sectors. Despite the marked differences between the three professions, the standards are drafted with a high-level of commonality. They then also incorporate discipline-specific references including details about professional capabilities and program and qualification attributes. This is consistent with the aims of the Harmonisation Project to ensure alignment in roles and processes between higher education providers and health professional accreditation authorities that may lead to a more streamlined approach.

A question underlying this discussion, therefore, is whether the current processes for the accreditation and re-accreditation of education programs are able to maintain pace with the need for workforce reform and adequately reflect the need for changing curricula.

Issues

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

Interprofessional education, learning and practice

Team-based health care delivery has been identified as an essential part of a contemporary and future focused patient-centred health services and an important contributor to the sustainability of the workforce in the face of financial and human resourcing constraints. The question for the Review is whether the current accreditation system has appropriate incentives to ensure interprofessional learning and practice are appropriately reflected in education programs.

The literature recognises interprofessional teamwork as an important contributor to positive health outcomes through improved communication, efficiency, cost effectiveness and the patient-centeredness of the health care team (McNair, 2005). In like manner, the World Health Organisation's (WHO) [Framework for Action on Interprofessional Education and Collaborative Practice](#) (2010) notes that interprofessional education (IPE) is a:

...necessary step in preparing a collaborative practice-ready health workforce that is better prepared to respond to local health needs.

The HPACF outlines in its guiding principles the need for interprofessional learning. These principles were reiterated in a [position statement](#) from its Interprofessional Learning Workshop 2015 which endorsed a shared definition and commitment to adopt a common statement for accreditation processes. However, progress in meeting this aim is variable. Some of the health profession accreditation standards already reference interprofessional learning, including:

Podiatry: The [Accreditation Standards for Podiatry Programs for Australia and New Zealand](#) (2015) specify that graduates understand the importance of interprofessional practice and are able to contribute to teams of health care practitioners in a cooperative, collaborative and integrative manner.

Nursing: [Registered Nurse Accreditation Standards](#) (2012) require that workplace experience opportunities are to be provided for intraprofessional and interprofessional learning and development of knowledge, skills and behaviours for collaborative practice.

Physiotherapy: [Accreditation Standard for Physiotherapy Practitioner Programs](#) (2016) specifies principles of interprofessional learning and practice are embedded in curriculum.

Australia, like many countries, has numerous positive IPE and collaborative practice examples. However, the sustainability of initiatives and projects is often precarious as they tend to be local, organisation based and/or dependent upon supportive champions. This raises questions as to the incentives and drivers required to systematically operationalise this concept into practice.

Responsiveness of curriculum design

As noted in the WHO's 2010 Framework, IPE must be purposeful, requiring supportive management practices, a resolve to change the culture and attitudes of professional bodies and workers, and a willingness to update, renew and revise existing curricula. For IPE to achieve its potential outcomes, educators and supervisors must be appropriately trained and supported to deliver and assess well-constructed learning outcomes (Stein, 2016) – irrespective of profession or discipline.

The literature highlights that IPE opportunities can be difficult to execute in an education provider's health programs due to issues such as entrenched professional and organisational cultures, financial resources, conflicting curricula, and supervision of clinical placements (Lawlis, 2014). This is also reflected in the WHO's [Interprofessional Collaborative Practice in Primary Health Care: Nursing and](#)

[Midwifery Perspectives. Six Case Studies](#) (2013) and was raised by some education providers during the preliminary consultation.

Since 2009, the Commonwealth Government has supported a tranche of work to consider opportunities to promote and develop IPE (as outlined in [Curriculum Renewal in Interprofessional Education in Health](#); Dunston, 2016). The work program included consultations to develop a coordinated approach to IPE and respond to health workforce reform initiatives. It is understood that the next phase for this work will involve working with stakeholders to consider opportunities and requirements for a national coordinated approach to IPE including curriculum renewal. Whilst this work has been and will continue to be of value, it is not clear whether there is universal acceptance of such a national and cross-profession approach.

As noted above, the redesign of health program curricula and processes for seeking accreditation can be detailed and time consuming and can limit the responsiveness to workforce priorities. Currently there is reliance on goodwill and cooperation with HPACF, amongst others, providing guidance and support to various initiatives. If IPE is agreed as a key requirement for preparing the workforce for future health service delivery, it raises the question of how best the configuration of accreditation authorities can lead and facilitate the transformation.

Responding to changing scope of practice

As community and social care needs have changed to require a more patient-centred, holistic and integrated approach to service delivery, the current delineated and siloed professional roles of the health workforce will also need to evolve to create common core and cross-professional capabilities. This is already reflected in the changing and broadening scope of practice for some professions including new skills development to reflect service demand.

The Commonwealth Government's Health Care Home model states its aim is to improve equity of access to health care and that this requires effective service coordination and a dedicated health care team working to the full scope of practice. This coordinated care approach is an example that will likely create opportunities for new and expanded roles including care coordinators and service navigators which will require common skills and may be performed by various health professions.

Given the ongoing and evolving need to modify workforce models in response to meet service demand, it raises the question of how the accreditation system might best facilitate professional education and practice reform in a manner that is agnostic to historical professional boundaries while recognising the central importance of professional competency. The current profession-specific approach limits consideration of cross-professional opportunities and inhibits workforce innovation. There are various options for addressing issues concerning the governance of accreditation processes, including a cross-professional mechanism for workforce reform, which are explored further in Section 5. Several have relevance to improving incentives and accountabilities for ensuring the prioritisation of interprofessional education and practice.

Issues

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

Clinical experience and student placements

Student placements are an essential element of the health professional curriculum. They provide students with an opportunity to turn knowledge learned in the classroom into practice and introduce students to a range of workplace settings and experiences.

The HPACF, in its [Essential Elements of Education and Training in the Registered Health Professions](#) (2015), identifies the importance of health programs providing a range of clinical education opportunities including ‘use of an appropriate variety of clinical settings, patients and clinical problems for training purposes’.

The preliminary consultation revealed that access to clinical placements and, in some cases, the fees charged by some health services for hosting these placements, was impacting upon the diversity of settings and experiences available to students to adequately achieve the skills and attributes required for professional practice.

Relevance of placements to support future health service delivery

As healthcare evolves towards more patient-centred, integrated care services, there is a need to ensure that clinical placement opportunities adequately reflect future community service need (Stein, 2016). Flexible and creative placements in ‘expanded’ and non-traditional settings (outside the acute system), and in areas such as outer-metropolitan, rural and regional areas, and with specific demographic groups such as disadvantaged communities, are necessary to ensure students are adequately prepared to meet future priorities.

In addition, the Health Care Home approach prompts a re-think by education providers and regulators about the training required to adequately prepare the next generation of health practitioners for team-based, primary care models.

All health professional accreditation standards note that the clinical placement experience should be structured to align with the required practitioner competencies. Some standards also reflect the need to undertake clinical practice in a diverse range of settings, for example:

Nursing: Standard 8 of the [Registered Nurse Accreditation Standards](#) (2012) states that each student is provided with a variety of workplace experiences reflecting the major health priorities and broad landscape of nursing practice.

Medicine: [Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council](#) (2012) notes that clinical placements should be structured to enable students to demonstrate graduate outcomes across a range of clinical disciplines including medicine, women’s health, child health, surgery, mental health and primary care.

This Review provides the opportunity to consider the role of the accreditation system in exploring and supporting clinical education in underserved areas or segments of the community.

Issues

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

Simulated clinical experience

Simulation-based Education and Training (SBET) is gaining acceptance as an evidence-based, education modality to develop skills, confidence and problem-solving abilities in a safe, controlled and monitored environment (Solymos, 2015). Whilst the Commonwealth Government, through Health Workforce Australia, made significant investments in simulation capacity-building projects to increase physical Simulated Learning Environment (SLE) resources and numbers of trained staff, there seems no overarching national approach or guidelines for the use of simulation in education and training.

SBET has been shown to improve knowledge, skills, attitudes, teamwork and communication, systems and processes, and the identification and mitigation of threats to safety (Gaba, 2004; Stone, 2016; Smith, 2015). SLEs are recognised as particularly useful to introduce students to critical care situations (Solymos, 2015) and team-based, interprofessional scenarios (Davis, 2016). They can also be used to assess performance and competence, potentially addressing the shortage of clinical learning opportunities and reducing pressure on health services to provide supervised clinical placements

The current accreditation standards vary on the acceptance of simulation as a standard component of the health curricula. Some examples include:

Podiatry: [Accreditation Standards for Podiatry Programs for Australia and New Zealand](#) (2015) note that possible examples of evidence could include ‘models of clinical education utilised, including details on use of emerging innovations for developing clinical competencies such as simulation’.

Occupational therapy: [Accreditation Standards for Entry-level Occupational Therapy Education Programs December](#) (2013) in Section 4, Practice Education/Fieldwork, notes that an education provider may include up to 20% of well-designed simulation experiences in the range of practice/education/fieldwork opportunities available to students.

Pharmacy: [Accreditation Standards for Pharmacy Programs in Australia and New Zealand](#) (2014), when referring to Experiential Placements, note that ‘simulated experiences may support the development of clinical skills and competences required by pharmacists to supplement and complement, but not replace, the placement experience’.

Whilst it is recognised that interaction with ‘real-world’ clients and situations are essential for the development of empathy and communication skills (Leonard, 2004), access to well-developed simulation scenarios, with well-trained educators and the appropriate coordination and support may enable simulation to become a standard component in clinical education and potentially alleviate pressures on training in the acute health sector.

Issues

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

The delivery of work-ready graduates

The desired outcome from an accredited health education program is a graduate who has the required knowledge, clinical skills and attributes to safely practice as a health practitioner (or to enter a defined period of supervised practice prior to general registration) and who has an appropriate foundation for lifelong learning.

Whilst for most professions the completion of an approved program of study meets the requirement for general registration there are expectations for Medicine and Pharmacy which require a twelve-month internship following graduation. In addition, Psychology provides for a dual pathway through either completion of a six-year degree or a lesser length degree and a one or two year internship.

Section 52 of the National Law provides the ability for a National Board to establish a registration standard requiring a period of 'supervised practice', which has been defined as internships by those National Boards. It also permits a National Board to require completion of an examination as a prerequisite for general registration.

These requirements are of interest to the Review given all such training posts, supervisory arrangements and outcome assessments require approval from the respective National Boards and are entirely input-focussed as they mandate the duration and location of such training, as well as specific practice areas. These arrangements have a cost and service impact on service providers where such training posts are located and obviously on graduates both in terms of personal costs and length of time before they can fully enter the workforce.

In considering this matter, the following initial observations can be made:

- Whilst the National Law permits registration standards that require a period of supervised practice, intern programs can also be arguably defined under the National Law as vocational education and training programs with clear learning outcomes and educational requirements obtained through support, feedback, teaching and assessment. This also places them within the scope of accreditation functions under the National Law.
- All intern programs require, in the first instance, mandated time spent with no capacity for individuals in the programs to demonstrate competency ahead of serving that requirement.
- All graduates have undertaken extensive clinical education already as part of their professional-entry qualification. It is expected that the level of clinical competence of a health professional will further change and develop with experience and professional development once in employment.
- There is a lack of definition of what 'work ready' means. In any business or service it is never expected that new graduates will be immediately able to demonstrate the capabilities and knowledge of experienced practitioners. Most employers acknowledge this and provide induction, support, orientation, mentoring and even further education to assist new graduates to develop their skills and to acclimatise to the particularities of a workplace.
- The literature, supported by comments from the preliminary consultations, notes that the areas that employers identify as 'work-ready gaps' of graduates seem to primarily relate to functioning as a health professional within a system, rather than lacking specific clinical and technical skills. A study by Merga (2016) identified these gaps as including caseload and time management, clinical administration, employability, conflict management, stress management and reality shock.

An approach to training that clearly addresses gaps in work readiness, and provides mentoring and support for students in the early phases of employment could better prepare graduates to operate safely, effectively and with greater confidence.

Issues

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?
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

National examinations

Health profession accreditation standards outline the need for evidence-based assessment mechanisms, undertaken by appropriately trained assessors, that ensure graduates meet the capabilities required to practice. In an outcomes-based approach to education, the assessment of competence requires observation that the student/graduate has achieved the learning outcomes and is 'work ready' as a qualified health professional. However, there is still the potential for variance in the measurement of competence and the knowledge, clinical skills and attributes of graduates across education providers, which can be due to factors such as the availability of resources and the abilities of educators and supervisors.

A National Board may decide to include the requirement for a national examination in its assessment of an individual's eligibility to practice as a health practitioner. This can be developed and/or conducted by the National Board or the accreditation authority. Some disciplines use a national standardised examination as part of the assessment pathway including:

Medical radiation: there are several situations where the Medical Radiation Practice Board of Australia may decide to use a national practice examination including:

- Before deciding an application for registration
- Where a practitioner is not qualified for general registration
- Where a practitioner is returning to practice after an extended break from practice
- Where there are concerns about a supervised practitioner's capacity for safe practise
- For practitioners who are granted limited registration

The online, multiple-choice examination is based upon the published medical radiation professional capabilities and is used in circumstances where a more detailed and objective assessment of a practitioner's capability to practice in the profession is required.

Pharmacy: The Australian Pharmacy Council conducts a written national examination for Pharmacy interns who have completed 30% of approved supervised practice hours (Note: from 2018, this increases to 40%). The Pharmacy Board of Australia then also requires Australian interns to complete an oral examination to receive general registration.

Given the current extensive and detailed accreditation process of health education programs, which are designed to ensure the achievement of desired outcomes, it raises the question of why national examinations for some professions (and not others) are necessary.

Whilst some evidence suggests that multiple choice tests do not adequately measure particular skills and could lead to distorted curriculum design and coaching, the addition of other informative processes such as skills assessment and reasoning tests have the capacity to determine the knowledge, skills, capacity for critical thinking, problem solving, ethical reasoning, independence and readiness for practice (Veloski, 1999).

A national approach to competency assessment of graduates has the potential to increase consistency of outcomes, create system-wide data to benchmark across education providers and their health programs, and deliver reliable, standardised information on graduate performance and quality. It may also facilitate a rationalised accreditation approach for assessing education programs, with the national examination being the means by which the measurement of individual competence for registration is achieved.

Issues

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

5 Producing the future health workforce



Previous Sections have considered issues relating to improving the cost effectiveness of accreditation functions and facilitating the relevance of, and institutional capability to deliver, health education.

This Section assesses the need for more fundamental reform of the accreditation system such that, together with related components of NRAS (AHPRA and National Boards) and other relevant parties (e.g. consumers, educational institutions, jurisdictions, employers, other accreditation regulators and professional associations), there are aligned incentives to produce a flexible, responsive and sustainable health workforce that delivers safe and high quality care. The assessment will include issues of governance, responsibilities and accountability, as well as consistency and collaboration across professions.

These issues will be examined from two perspectives:

- The extent to which the accreditation function provides the level of independence from the registration function and from other vested interests, such that the public interest is paramount and the objectives of the Scheme are being met.
- The processes by which accreditation functions within NRAS can be best informed of, and be able to respond to, workforce developments that arise from evolving health care needs.

Regulation of the various health professions has evolved to become a complex and polymorphic system with multiple objectives. Whilst the COAG reforms have transformed registration and accreditation from a state based to a national scheme, there is still significant complexity of governance arrangements and responsibilities for the education and regulation of the health workforce and this complexity may not be optimal in progressing government objectives to develop a sustainable health system.

This is significant given that the powers to accredit the education delivered to health practitioners for purposes of their registration, and to assess overseas trained practitioners, are pivotal elements of contemporary health practitioner regulatory systems. These functions, if not carefully managed, can hamper the continued evolution of health care in response to changing needs of the population and, in some instances, can also effectively create significant barriers to entering the market as providers of health services.

Independence in regulation

Regulation is a mechanism through which government can aim to safeguard the welfare of the community and protect the public interest. It generally involves the administration of any rule put in place with government authority. In this context, COAG has set criteria for the inclusion of professions into the Scheme only where it could be demonstrated that the occupation's practice presents a serious risk to public health and safety which could be minimised by regulation.

Regulators ensure the proper delivery of many public and private services. However, regulators can fail to protect the public interest if their activities are unduly influenced, whether by the regulated industry, government or outside interest groups. Most systems across the world thus operate regulatory models that separate the policy advice and direction function from the the body which administers the policy. This separation is often embodied in law and is regarded as best practice governance. It has been at the heart of much public sector reform in Australia and internationally.

In 2012, the Council of the OECD adopted the [Recommendation of the Council on Regulatory Policy and Governance](#). According to these recommendations, independent regulatory agencies should be considered in situations where:

- *there is a need for the regulator to be seen as independent, to maintain public confidence in the objectivity and impartiality of decisions; or*
- *both government and non-government entities are regulated under the same framework and competitive neutrality is therefore required; or*
- *the decisions of the regulator can have a significant impact on particular interests and there is a need to protect its impartiality.*

In considering regulatory independence, it is important to be clear that it is not an end in itself but rather a means toward ensuring effective and efficient service delivery by those subject to regulation. Independence cannot come at the price of accountability.

Regulation, by its very nature, requires a source of regulatory authority. The most appropriate locus of this authority was vigorously debated in setting up the NRAS in 2010. This reflected a tension between efforts of some professions to maintain a level of self-governance and governments' attempts to develop a more independent, actively managed and responsive externally regulated system. This was in response to concerns that where professions operate as self-regulatory institutions they can benefit from a triple monopoly – economic, political and administrative.

This system shift and dealing with the accompanying tensions is a common development across most health systems globally. This was noted by the [WHO European Observatory on Health Systems and Policies](#) in its analysis of continued practitioner regulation reform across the European Union that arose from calls for closer public scrutiny of professional activities. There has been:

...the emergence of new externalized forms of control and the development of new reporting lines - upwards to governmental or independent regulatory agencies and downwards to consumers and citizens.....Other social actors, not only governments but also managers, parliaments and the general public, have assumed increased responsibility for overseeing professional activity and defining the framework of self-regulation.

Interdependence of accreditation and registration

Whilst registration gives practitioners the legal right to practice, the accreditation functions provide the threshold assessment and evaluation of education and training courses to 'guarantee' standards of health professional education and training for an individual's entry into a profession in the first instance. In the context of this Review, the activities performed by accreditation authorities are part of the regulatory framework, and there must be an expectation that, at least at the system level, the 'regulator/s' governance and accountability arrangements should ensure that all decisions and activities are objective, impartial, consistent, expert and transparent.

This highlights the threshold question of whether the regulatory accountability for accreditation should be separate and at the accreditation function level or, as at present, at the National Board level, with accreditation authority activities considered purely administrative actions delivered by contracted service providers.

The Productivity Commission (2005) adopted a principle of reflecting the process of accreditation through separate regulation:

...it would be good regulatory practice to separate the setting and verification of standards at the education and training institutional level from the application and maintenance of standards in relation to individual practitioners. Further, the Commission believes it is possible to establish two separate boards — accreditation and registration — on an ‘impartial and independent’ basis.

The [Intergovernmental Agreement](#) signed by COAG in 2008, however, brought these two processes together through the one national agency (AHPRA). Its role was to set frameworks and requirements for the development of registration, accreditation and practice standards by the National Boards to ensure that good regulatory practice is followed in accordance with the objectives of the legislation and any policy directions of Health Ministers.

As a transitional measure, the Intergovernmental Agreement provided that the Ministerial Council would assign accreditation functions to existing accreditation bodies, with the requirement that they meet standards and criteria set by the national agency for the establishment, governance and operation of external accreditation bodies and that:

- 1.36. *Within three years, in consultation with the relevant accreditation body and the profession, the relevant board will review this assignment and the future arrangements and make a recommendation to the Ministerial Council on the best future arrangements for its profession.*
- 1.37 *Ongoing decisions about whether external bodies should continue to perform accreditation functions will be taken by the Ministerial Council following consultation with the boards.*

Whilst requiring the review of assignment of accreditation functions within three years, the finally agreed National Law that came into effect, however, critically shifted responsibility for the determination of how accreditation functions on an ongoing basis would be delivered to each National Board (s43) rather than to the Ministerial Council.

National Boards undertook a review of their arrangements in 2012 and all endorsed the continuation of their external entities under the National Law to exercise accreditation functions – albeit in some cases for periods of only one or three years (all of which were subsequently extended).

Under NRAS, education accreditation is an antecedent function to registration and the work of the accreditation authorities is subsidiary to decisions of National Boards. The National Law is clear that the National Boards are the final decision makers on the accreditation standards and programs of study, as well as on whether a professional will be registered:

- While each council/committee is required to develop accreditation standards for their profession, they must submit them to their National Board for approval (which the National Board may approve, refuse to approve or ask for a review) (s47).

- A National Board may also approve (with conditions if it so chooses) or refuse to approve a program of study provided by an education provider that has been accredited by the council/committee as providing a qualification (comprising knowledge, clinical skills and professional attributes) for the purposes of registration in a health profession (s49).

In both perception and operation, there appear to be different views on what the independence of the accreditation entities in this context means. Whilst their operations remain largely independent, ultimately decisions on both accreditation standards and the approval of programs of study against those standards for all registered professions remain entirely within the province of the National Boards.

As discussed in Section 4, delivering a health workforce that is responsive to the emerging needs of the community requires a flexible and adaptive accreditation system which proactively recognises emerging health and social care issues and priorities, and which provides direction to education providers so that curricula appropriately reflects best practice and is evidence based.

The current subsidiary relationship of accreditation authorities to National Boards has the potential to constrain the most appropriate education and training of health practitioners. National Boards, by virtue of their role and composition, may institutionally (and arguably appropriately) be risk averse and also not necessarily have the expertise in education approaches and the changes needed for a rapidly evolving health system.

Issues

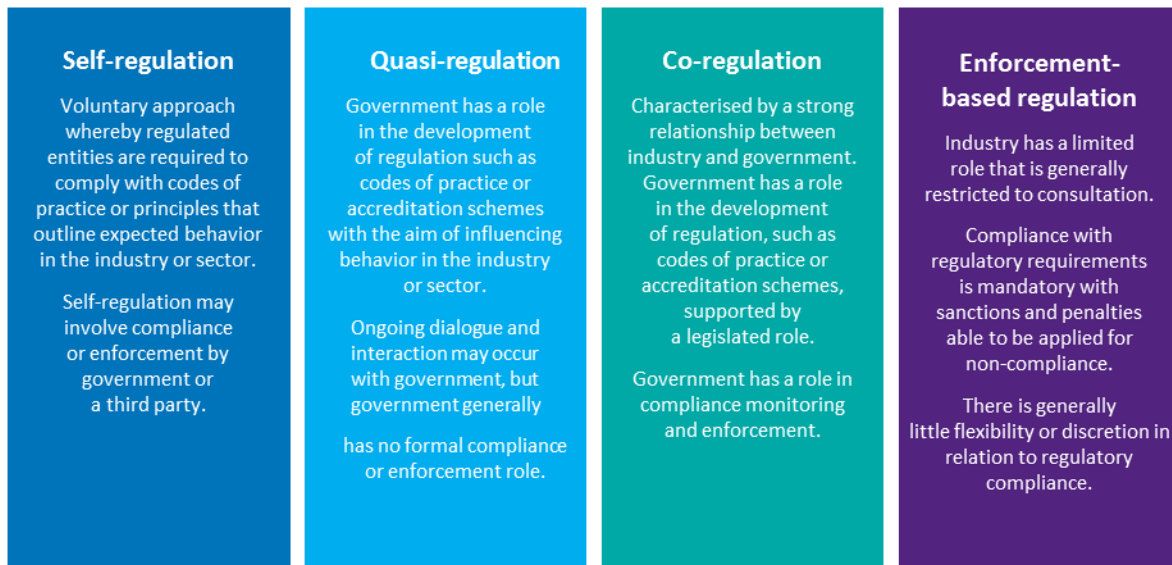
19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?
20. Would greater independence of accreditation authorities, in the 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 independence of accreditation from other stakeholders

The focus on the independence of accreditation in the legislation and regulations has been largely on independence from government. Effective independence however, should be conceived not only with reference to governments, but also with respect to representatives of the sectors targeted by regulation, and thus include a wide range of public and private stakeholders.

The role of governments

Any consideration of independence must acknowledge that a regulator's 'independence' from government can never be absolute, rather is a matter of degree and nature and that it should be clearly established – usually through statute. In considering what particular type of statutory governance arrangements and responsibilities can be applied in any independent regulatory model, the [Australian National Audit Office](#) (ANAO) depicted the continuum of approaches as follows:



The health system is a network of governance mechanisms that enable the policy, legislation, coordination, regulation and funding aspects of delivering quality services to operate in a collective set of interdependencies. These matters are complex, as is the planning and delivery of services, given that it is shared between several levels of governments and multiple agencies of those governments as well as private businesses and the not-for-profit sector. In this environment governments face large and intractable challenges, with many dimensions, multiple stakeholders, and far-reaching impacts and ripple effects.

In many aspects of health care delivery, Australian governments have adopted a stewardship role in their focus on providing the policy settings and regulatory regimes to oversight and ensure that service delivery (often directly by themselves) and public expenditure are in the public interest. The [World Health Report 2000](#) - Health Systems: Improving Performance (WHO, 2000) identified stewardship as one of the four key functions for governments in health system management and policy making, the other three being providing services, generating the human and physical resources that make service delivery possible, and raising and pooling the resources used to pay for health care.

The government is particularly called on to play the role of a steward, because it spends revenues that people are required to pay through taxes and social insurance, and because it makes many of the rulesand part of the state's task as the overall steward or trustee of the system is to see that private organisations and actors also act carefully and responsibly. A large part of stewardship consists of regulation, whether undertaken by the government or by private bodies which regulate their members, often under general rules determined by government.

The National Law has generally adopted this stewardship concept in that it has provided some roles for government in the regulation of health practitioners but has largely established a regulatory regime that is not under direct governmental control. In the context of accreditation of education and recognition of qualifications for registered professions, the Ministerial Council has only a limited role in the approval of accreditation standards. Whilst some aspects of the Scheme can be largely regarded as being co regulatory, in terms of accreditation the model equates more to a quasi-regulatory approach on the ANAO continuum.

Whilst the assessment of education programs against accreditation standards clearly requires objectivity and independence, the initial setting (and review) of the accreditation standards can effectively set policy directions for health education, such as its level of emphasis on interprofessional approaches that better align to expected service demand and workforce innovation. Whether the government's role in setting and monitoring these policy directions in the public interest is adequately provided for in NRAS is discussed later in this Section.

The involvement of non-government stakeholders

The National Law does not specify how independence from the sectors targeted by regulation should be addressed in carrying out the accreditation function. Part 6 of the National Law does impose some procedural requirements on the accreditation authority that include:

- Publishing how it will exercise its accreditation function
- In developing accreditation standards, undertaking wide ranging consultation about their content
- Providing written notice to the education provider of a decision to refuse to accredit a program of study
- Conducting internal reviews of a decision to refuse to accredit a program of study, if requested by the education provider
- Monitoring programs and education providers

The National Law provides for community involvement in the operations of the National Boards. The Review has observed that AHPRA actively supports the community members and provides opportunities for them to engage with each other. This can limit 'capture' of the members by the interests of the professions, particularly when trying to understand and evaluate matters relating to a health system where information asymmetry is often a hallmark of the relationship between health professionals and health consumers (the patients they treat and their carers).

There are no specific requirements under the National Law, nor under the contractual agreements with accreditation authorities, regarding community involvement in carrying out their functions.

Governance of accreditation authorities

There are two governance structures set out as options in the National Law. As noted in Section 2, they are either committees of National Boards or external entities (councils). This is a matter for decision by the Boards.

Accreditation committees, being creations of the National Boards, have different governance issues compared to councils. In particular, the membership of the committees is the direct prerogative of the National Boards and this can influence the decisions of the committees.

Where councils have been assigned the accreditation function, the overarching principles for their operation were agreed between AHPRA, the National Boards and the accreditation councils themselves and published in the promulgation of an agreed Quality Framework (see Section 2). The Review is examining whether these governance arrangements, both real and in perception, are adequate in terms of:

- Providing independence in the delivery of standards and assessments, with a view to fostering accountability, transparency, trust and a focus on the public interest.

- Performance against NRAS objectives and guiding principles.
- The exercise of administrative discretion effectively constituting regulation and thus avoiding the various checks and balances in regulatory scrutiny.

The above-mentioned Quality Framework requires that the external accreditation authority carries out its accreditation operations independently, that decision-making processes are independent and there is no evidence that any area of the community, including government, higher education institutions, business, industry and professional associations, has undue influence.

The Quality Framework also establishes a number of governance attributes, including:

- The accreditation authority is a legally constituted body, is registered as a business entity and can demonstrate business stability.
- The accreditation authority's governance and management structures give priority to its accreditation function relative to other activities (or relative to its importance).
- There is a transparent process for selection of the governing body.
- The accreditation authority's governance arrangements comply with the National Law and other applicable legislative requirements.

Given the legal construction of councils, there is a need to achieve a balance between director's duties in managing a legally constituted company with shareholders/members and performing functions under NRAS. The Corporations Act 2001, Australian Securities and Investments Commission Act 2001 and various standards or guidelines issued by the Australian Securities and Investments Commission or the Australian Charities and Not-for-profits Commission may not always be in synch with a council's obligations in running a scheme for public benefit. The focus of directors in this regard is not on how the National Boards conduct their own affairs, but rather on the specific responsibilities for the development and approval of accreditation standards, educational programs and the qualifications of overseas practitioners seeking to work in the Australian healthcare system.

The makeup of each council's governing board is a key factor in considering its institutional independence and underlying ability to deliver on the objectives of NRAS and the reform directions in the health system more generally. While noting that the Quality Framework requires that there is a transparent process for selecting the governing body, at this stage of the Review it is difficult from the available public information to identify all board members' affiliations and background.

Our initial analysis of annual reports, web sites and council constitutions suggests the following:

Representatives from the profession	Representatives from education providers	Representatives from a member organisation	Non-health profession members
35	28	25	19

In compiling these figures, it should be noted that:

- Representatives from education providers and from nominating member organisations are almost always also members of the relevant profession.
- Non-practitioner members are primarily people with expertise in corporate governance with a much smaller subset appearing to be community members specifically selected to represent the interests of healthcare consumers.
- Not all council membership requirements and processes for appointment of directors are clear from publicly available documentation and further investigations will be required.

It is important to ensure expert input from members drawn from the professions, education providers, consumers and governance (finance and law). It is also important, however, that authorities are protected from the risk of stakeholder capture and that decisions are made in an objective manner in the public interest. This becomes even more critical if consideration is to be given to providing more independence in decision making to the accreditation authorities.

A substantial number of members to be appear selected on the basis of being a nominee of member organisations (eg. industrial organisations, professional associations, education providers and other representative or umbrella councils). These bodies have a deep interest in the matters being regulated and can be affected by the decisions that are made. Again, professional input to, and involvement in, key elements of the accreditation regime is critical but the sourcing of that input should be based on the expertise of individuals rather than being seen to be potentially representing the interest of particular organisations.

Whilst it would be expected that robust conflict-of-interest policies could deal with individual program accreditation decisions, the strategic nature of accreditation standards and their impact on the current and future functioning of the health system makes consideration of this principle in the development of standards particularly pertinent. In 2014, the OECD produced a set of agreed principles for governance models for regulatory authorities. In relation to the role of stakeholders that have an interest in the decisions made by the authorities, [The Governance of Regulators](#) (OECD, 2014) stated:

To avoid conflicts of interest, where there is a need for formal representation of specific stakeholders in strategic decision making, stakeholder engagement mechanisms such as an advisory or consultative committee should be established, rather than making those stakeholders members of the regulator's governing body.

The Review is exploring arrangements, either within current governance regimes or alternatives, that address the various governance issues discussed in this Section.

Issues

21. Is there adequate community representation in key accreditation decisions?
22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?
23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

Role of accreditation authorities

The relationship between each Board, AHPRA and accreditation council is managed through a standard funding agreement with AHPRA and a profession-specific schedule outlining deliverables and reporting requirements. Accreditation authorities are required to report on some indicators twice yearly, with a more comprehensive report to be provided annually.

There is a standard clause in each 2015/16 agreement that states the following:

The Council and the Board note continuing interest in demonstrable changes in line with the following goals as part of the broader context for the Accreditation Functions within the National Registration and Accreditation Scheme (the Scheme):

- *opportunities to increase cross-profession collaboration and innovation, including to address the guiding principle of the National Law that the Scheme is to operate in a transparent, accountable, efficient, effective and fair way. For example, joint projects with other accreditation entities or through the Health Professions Accreditation Councils' Forum;*
- *opportunities for the Council to facilitate and support inter-professional learning in its work; and*
- *opportunities for the Council to encourage use of alternative learning environments, including simulation, where appropriate.*

The Council will advise the Board about current activity to address the issues outlined as part of its first routine report in the 2015/2016 financial year. The Board and Council will subsequently share information about health workforce reform issues when relevant to the xxx profession.

The Review is exploring whether this clause is being acted on in a sufficiently timely and fulsome manner and, if not, whether there needs to be an external driver that is neither a National Board nor an accreditation authority.

Issues

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?

Role of the Health Professions Accreditation Councils' Forum

Under the National Law, whilst the individual accreditation functions continue to be exercised by profession-specific bodies, another vehicle for improving approaches to cross-profession and interprofessional accreditation and education is through the HPACF.

The HPACF was initially established in 2007 when COAG was discussing the Intergovernmental Agreement on the national registration of health practitioners. Members are those independent legal entities appointed by the respective National Boards as the external accreditation authorities for NRAS (i.e. the councils). It does not include the three accreditation committees established under the National Law, nor any accreditation bodies for the self-regulated health professions.

The HPACF's stated purpose (as provided on its website) is to:

- Work together on issues of national importance to the regulated health professions
- Identify areas of common interest and concern in relation to the regulated health professions
- Work toward a position of consensus on identified issues and concerns
- Take joint action in areas of importance to the regulated health professions
- Develop joint position statements which provide recommended policy directions for governments and other relevant stakeholders

As noted earlier in the Discussion Paper, HPACF has issued a number of position statements on matters relating to its members' functions and advises that it meets annually with all National Boards and AHPRA to discuss how to build the effectiveness of NRAS, particularly in accreditation.

As an accreditation system-level governance model, HPACF has proven to be a valuable initiative of the various accreditation authorities and has achieved a number of improvements to the accreditation system. However, it also has several limitations:

- It is not an established body under the National Law and has no formal status.
- It is financially constrained – for instance, it does not receive funding from AHPRA to undertake any of its activities or to progress broader reform priorities.

What other governance models might be considered?

The Productivity Commission 2005 report, in recommending the establishment of a single statutory national accreditation board for health workforce education and training, concluded that:

Current accreditation arrangements can inappropriately reinforce traditional professional roles and boundaries, and thus impede job innovation. Inconsistent requirements imposed on educational institutions and trainers by different agencies create further inefficiency.

A national cross-profession approach to accreditation would preserve the best features of current arrangements while facilitating:

- *More timely and objective consideration and adoption of beneficial cross-profession job evolution and redesign options*
- *Interdisciplinary and multidisciplinary education and training and articulation between VET and higher education and training*
- *Improvements in the appropriateness and consistency of accreditation in the different professions; – uniform national standards on which to base professional registration*
- *Reductions in administrative and compliance costs*

Those 2005 recommendations highlighted an important issue - to achieve the broad reform intentions, education needs to support the development of a workforce that is more flexible, responsive and sustainable and enable innovative improvement in service delivery.

Governments are also increasingly recognising that the delivery of health services must be planned and delivered in a broader context that takes account of interactions of health interventions with social and other services in responding to community issues. The delivery of such integrated service responses is aimed at having a greater client focus, improving health and wellbeing, tackling issues

associated with social disadvantage and improving outcomes. This is particularly relevant for those individuals and households with multiple and complex needs spanning issues such as mental health, insecure housing, family violence, drugs and alcohol, chronic health conditions and disability.

This environment will involve joined up service delivery which connects many additional professions outside the remit of NRAS. Whilst there are important additional requirements and standards that registered health practitioners are required to meet, there is a risk that the various NRAS functions will become a silo in themselves by virtue of only considering the education and practice of the registered health professions.

The HCPC in the UK has been set up as an umbrella regulator which currently includes Chiropodists/Podiatrists, Dietitians, Occupational Therapists, Operating Department Practitioners, Orthoptists, Paramedics, Physiotherapists, Practitioner Psychologists, Prosthetists / Orthotists, Radiographers, Social Workers and Speech and Language Therapists. The HCPC sets standards for the education and training, professional knowledge, skills, conduct and performance of registrants and approves education programs.

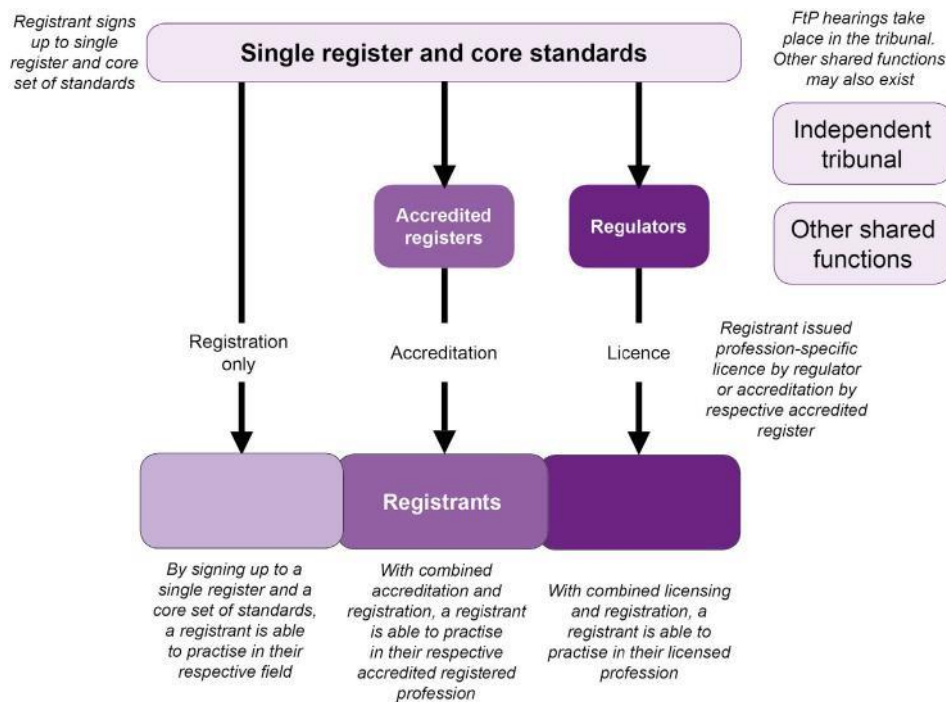
The HCPC [standards of proficiency](#) for registrants include both common and profession-specific elements. Its standards of education and training are common across professions and cover the level of qualification, program admissions, program management and resources, curriculum, practice placements and assessment. Benefits of the model are demonstrated in such areas as consistent expectations for inter-professional education, consumers and care involvement, etc. Importantly, the HCPC also provides a single and consistent approach to accrediting education programs against those standards through its Education and Training Committee – which has been given statutory responsibility for approving and monitoring education programs.

Whilst the HCPC does not cover many of the professions under NRAS, of interest is also the PSA in the UK. The PSA is responsible for overseeing not only the HCPC but also the:

General Chiropractic Council	General Dental Council
General Medical Council	General Optical Council
General Osteopathic Council	General Pharmaceutical Council
Nursing & Midwifery Council	Pharmaceutical Society of Northern Ireland

The PSA also provides policy advice to government, reports to parliament on regulators' performance, undertakes investigations commissioned by and for government, and accredits voluntary registers held by non-statutory regulators of health and care professionals. It has produced a set of best practice standards against which it assesses the performance of the regulators it oversees.

Most recently the PSA has been undertaking a research program focussed on analysing the UK health and social care professions regulatory framework. Its recent discussion paper [Regulation Rethought - Proposals for Reform](#), released in October 2016, references a number of the benefits demonstrated through the establishment of AHPRA in Australia and proposes an extension and enhancement of the model to create a single assurance entity for all health and care occupations as depicted in the following diagram:



Amongst many of the benefits the PSA sees in such a model are:

- A shared ‘theory of regulation’ based on right-touch thinking
- Shared objectives for system and professional regulators and greater clarity of roles
- Transparent benchmarking to set standards
- A reduced scope of regulation so that it focuses on what works
- A proper risk assessed model of who and what should be regulated put into practice through a continuum of assurance
- Breaking down boundaries between statutory professions and accredited occupations
- Making it easier to create new roles and occupations within a continuum of assurance
- A drive for efficiency and reduced cost which may lead to functional mergers and deregulation

The model is similar to that proposed by the Productivity Commission in 2005 and, whilst the overall concept is beyond the terms of reference of this Review, it does provide valuable insight into similar issues being explored around the accreditation of education. The 2016 PSA discussion paper notes:

Educators too are affected by multiple regulators with different standards and quality assurance mechanisms. This may inhibit their ability to train practitioners who are centered on patients’ needs, with shared values, and who can work across professional boundaries within health and care. Team roles and functions may change as population needs, technological innovations or service requirements alter. Those striving to re-design service delivery, integrate care, or introduce new working practices may be frustrated and delayed by the difficulties inherent in flexing scopes of practice or creating new roles, because of protected titles and boundary protection by particular professions.

In considering how the governance of accreditation functions might be approached to better respond to the ever-increasing complexity of interaction across the range of support systems, the Review is examining a number of possible options.

Agency Management Committee

A first step might be to expand the remit of the AHPRA Agency Management Committee. The unique umbrella and multi-level nature of responsibilities under NRAS provides the opportunity for substantial delivery of single oversight and support for the implementation of an integrated reform agenda within the current structure of the Scheme. The National Law gives the Committee the following functions:

s30 Functions of Agency Management Committee

(1) The functions of the Agency Management Committee are as follows—

- (a) subject to any directions of the Ministerial Council, to decide the policies of the National Agency;*
- (b) to ensure that the National Agency performs its functions in a proper, effective and efficient way;*
- (c) any other function given to the Committee by or under this Law.*

The Agency Management Committee's role to date has largely focussed on bedding down the procedural operations of NRAS. However, as NRAS progressively improves its efficiency and effectiveness, the Committee's function of deciding on the policies of the AHPRA could come to the fore. As an independent governance body, it may be well placed to take on the role of objectively developing rigorous directions for the development of accreditation standards, embedded within the AHPRA/council agreements.

The Agency Management Committee would be guided by the National Law's objectives and guiding principles and set directions to achieve efficiency and effectiveness, consistency across professions, promotion of flexibility and innovation in education, and related accreditation improvements. For such a regime to work, a clear delineation would need to be made between the Committee's scope of interest and those of the expert accreditation authorities.

A single national accreditation organisation

Another option might be to consider the type of model proposed by the Productivity Commission in 2005, being a single national accreditation organisation for health workforce education and training, supported by subsidiary expert bodies.

In recent years, a national accreditation model has been put in place for the development and management of the [Australian Health Service Safety and Quality Accreditation \(AHSSQA\) Scheme](#). This Scheme provides for the national coordination of accreditation processes against the [National Safety and Quality Health Service \(NSQHS\) Standards](#). It contains some similar elements to the NRAS approach with an umbrella organisation, the Australian Commission on Safety and Quality in Health Care (ACSQH), which:

- Develops and maintains the NSQHS standards
- Approves expert accrediting agencies against specified criteria to assess health service organisations against the standards
- Undertakes ongoing liaison with state and territory health departments on opportunities to improve the Standards and the accreditation system
- Monitors and reviews the approved accrediting agencies

- Hears complaints about decisions made by accrediting agencies
- Reports to Health Ministers annually on safety and quality

A threshold requirement for any accrediting agency to be approved is that it must hold current organisational accreditation with an international recognised body. ACSQH quotes as examples the International Society for Quality in Healthcare (ISQua) and the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). Third-party accreditation provides an assurance mechanism to clients, funders and other stakeholders that the external evaluation and standards setting organisations and their standards and assessor training programs meet international best practice requirements.

An important component of ACSQH's overall role is its focus on continuous improvement around the nature and currency of the standards, assessment mechanisms and overall performance of the scheme. This is also reflected in another major focus of ACSQH on credentialing. This is a process used by health service organisations to verify the qualifications and experience of health practitioners to determine their ability to provide safe, high quality health care services within specific health care settings.

Credentialing has the potential to improve safety for patients by ensuring clinicians practice within the bounds of their training and competency, and within the capacity of the service in which they are working. A [National standard for credentialing and defining the scope of clinical practice](#) of medical practitioners, for use in public and private hospitals was developed by the former Australian Council for Safety and Quality in Health Care in 2004.

The ACSQH advises that implementation of the national standard is underway in all jurisdictions and across the private hospital sector and that the structures and processes being used vary between states and different health care settings. Credentialing by health services has largely focused on specialist medical practitioners, but it has the potential for wider application to other health professions.

Consideration of a more unified accreditation regime also has the potential to more actively create common core and cross-professional capabilities and expanded roles, as discussed in Section 4. There is currently no clear and consistent process for dealing with developing practice standards, curriculum design and accreditation standards for new or enhanced roles.

The current profession-specific approach limits consideration of cross-professional opportunities and inhibits workforce innovation. An example of how such initiatives can become protracted is the Health Workforce Australia project to develop a nationally consistent approach for prescribing by health practitioners, building on a set of [prescribing competencies](#) developed by the National Prescribing Service. The project aimed to deliver a consistent platform by which health practitioners other than medical practitioners may undertake prescribing of medicines consistent with their scope of professional practice. Whilst the project commenced in 2012, it appears it has taken over four years to reach agreement between stakeholders and the issuing of an AHMAC [Guidance Note](#) in December 2016 on how individual National Boards may make application to the Ministerial Council approval of the terms of a new scheduled medicines endorsement or amendment. The application process itself also remains profession specific and outlines a further lengthy process for individual applications.

Whilst not all such role developments would necessarily have a registration impact, a more robust and global accreditation system might be able to play a substantive role in setting education standards and accrediting post-graduation education and training packages for enhanced scopes of practice and cross-professional capabilities. This would be particularly beneficial where existing profession specific arrangements can represent a barrier to reform, such as where there are disputes over professional boundaries.

The final consideration in looking at potential governance models is the need to take into account the number of accreditation regimes in the health and human services space and what opportunities there might be for better alignment or even integration. References have already been made to TEQSA and ASQA and the need to take account of relevant professions which are not part of NRAS.

Interestingly, the Australian Commission on Safety and Quality in Health Care outlined above also lists one of its success measures in its [Strategic Plan 2014 – 2019](#) as:

Safety and quality are considered as important aspects of undergraduate and postgraduate curricula for health professionals

Noting this and other overlapping accreditation functions, it further suggests potential benefits in considering some form of umbrella governance that could identify and resolve overlaps, inefficiencies and duplication both across systems and professions.

Issues

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.
26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

Accountability and performance monitoring

Irrespective of how the future governance of the accreditation system is determined, it should be an expectation that regulators need to be accountable and that consistent and comparable reporting on, and measurement of, quantitative and qualitative performance metrics are included.

Reporting must be against a comprehensive suite of meaningful performance indicators that are set with reference to the goals they are expected to achieve. Public reporting improves public confidence in the system by demonstrating how well regulatory objectives are being met, allows the regulator to be assessed and held to account and provides an incentive to improve performance. Quantitative performance metrics should also be linked to broader policy objectives and justify the part those metrics play the achievement of those objectives.

Key performance measures should also be incorporated into planning systems and investigated and acted upon when required. Whilst a review of AHPRA annual reports reveals comprehensive reporting on key registration, notification and practitioner performance indicators, reporting on accreditation metrics is less consistent, both within and across the regulated professions.

The lack of consistency in what is reported in these domains is likely to be a result of the nature of the relationship between National Boards and accreditation authorities and differing views on the responsibility for compiling and reporting on such metrics. Whilst some of these metrics can be found in external accreditation councils' annual reports, the Review considers it important that agreed key metrics form part of core NRAS indicators to enable the assessment of activity both within and across professions. It is worthwhile also noting that, currently, these are only quantitative metrics and do not go to reform or quality objectives.

Robust quantitative and qualitative metrics would need to be carefully developed and applied consistently across the accreditation functions. Such metrics should provide additional focus on the reform objectives of governments. Workforce reforms encompass multiple domains and within each of these there are multiple levers for policy action that can be used at different levels of the health system. A broad system approach stresses the interconnectedness of strategies in these domains and may prevent problems that are more likely to arise with a reductionist focus on a single factor.

Current arrangements do not necessarily provide for whole-of-system monitoring for the accreditation functions encompassed in the Scheme, nor provide through such monitoring a holistic assessment of all aspects of performance and health workforce reform. Substantial benefit could be provided to the Ministerial Council and AHMAC if there was a capability within NRAS to whole of system performance monitoring and reporting that could then be considered in the context of wider system reforms.

Whilst the HPACF has been a valuable contributor to this whole-of-system approach and has provided some reporting and monitoring capacity, the Review is exploring how best an independent and integrated performance monitoring capability might be provided.

Internal performance evaluation is critical as part of good internal governance practices. It is also important however, to have external performance evaluations that can complement and support the internal reviews. Internal performance evaluations should focus on the systems, processes and procedures and assess overall operations and external reviews should focus on whether the strategic goals are being met, including examination of any particular decisions of the regulatory body in cases where they have a strategic significance.

As outlined earlier, the PSA in the UK oversees the statutory bodies that regulate health and social care professionals. Its primary performance functions are to:

- Assess statutory bodies' performance, conduct audits, scrutinise decisions and report to Parliament.
- Share good practice and knowledge, conduct research and monitor policy developments in the UK and internationally.

The PSA has a much broader remit than the scope of this Review. It does, however, include monitoring and reporting on the various education accreditation functions undertaken by those statutory bodies and is uniquely placed to provide a whole-of-system perspective. Noting the breadth and complexity of the Australian health system, the Review is considering whether providing similar capacity within the NRAS governance structures to monitor performance from a whole-of-Scheme perspective might provide benefit.

Issues

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?

Setting health workforce reform priorities

A key issue raised in the initial consultations has been the role of the various governance bodies in NRAS in responding to health system and health workforce priorities. Several stakeholders involved in accreditation have stated that it is not their responsibility to set the priorities but they could more effectively respond if there were better arrangements in place to advise them of those priorities.

This seems to be similar to a conclusion reached in the 2014 NRAS Review.

This Review found that little attention has been directed towards understanding and designing the regulators' response to health workforce reform in the early stages of the National Scheme. Its importance is being increasingly recognised with the formation of cross-profession forums and the involvement of the Australian Health Ministers' Advisory Council (AHWAC) as a means of improving mutual understanding about the future agenda in workforce reform. While this recent development is encouraging, the National Scheme needs to have very specific and measurable targets to deliver on the health workforce reform agenda.

Section 19 of the National Law provides for AHWAC:

The function of the Advisory Council is to provide independent advice to the Ministerial Council about the following—

- a) any matter relating to the National Registration and Accreditation Scheme that is referred to it by the Ministerial Council;*

- b) *if asked by the Ministerial Council, any matter relating to the National Registration and Accreditation Scheme on which the Ministerial Council has been unable to reach a decision;*
- c) *any other matter relating to the National Registration and Accreditation Scheme that it considers appropriate.*

The decision on the future of AHWAC was referred to the 2014 Review for advice. It recommended that a new body be established (known as the Professional Standards Advisory Council) to advise the Ministerial Council on key matters of interest to the Council in the performance of NRAS. The Ministerial Council, in responding to the 2014 NRAS Review, determined that it did not support the establishment of a Professional Standards Advisory Council. Health Ministers accepted that improvements to governance, reporting and reform arrangements are necessary, but determined that this should be achieved through existing structures including the Agency Management Committee and AHMAC.

Consultations to date have highlighted that accreditation authorities lack clarity and certainty regarding reform expectations and have indicated that there is support for a process whereby consistent and regular advice can be provided. The Review is examining opportunities to better embed this within existing NRAS structures, as well as ensuring that there is a regular and consistent mechanism for communicating government policy direction.

Under current legislative provisions the Ministerial Council can provide a range of advice and directions to NRAS. Section 11 of the National Law provides:

s11 Policy directions

- 1) *The Ministerial Council may give directions to the National Agency about the policies to be applied by the National Agency in exercising its functions under this Law.*
- 2) *The Ministerial Council may give directions to a National Board about the policies to be applied by the National Board in exercising its functions under this Law.*
- 3) *Without limiting subsections (1) and (2), a direction under this section may relate to—*
 - a) *a matter relevant to the policies of the National Agency or a National Board; or*
 - b) *an administrative process of the National Agency or a National Board; or*
 - c) *a procedure of the National Agency or a National Board; or*
 - d) *a particular proposed accreditation standard, or a particular proposed amendment of an accreditation standard, for a health profession.*
- 4) *However, the Ministerial Council may give a National Board a direction under subsection (3)(d) only if—*
 - a) *in the Council’s opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners; and*
 - b) *the Council has first given consideration to the potential impact of the Council’s direction on the quality and safety of health care.*
- 5) *A direction under this section cannot be about—*
 - a) *a particular person; or*
 - b) *a particular qualification; or*

c) a particular application, notification or proceeding.

6) The National Agency or a National Board must comply with a direction given to it by the Ministerial Council under this section.

Section 11(3) explicitly states that there is no limitation on the Ministerial Council's capacity to direct both AHPRA and National Boards in the application of policies. The Review is examining whether the legislation provides certainty in allowing the Ministerial Council to direct policy parameters for accreditation standards on its own motion and in the absence of a proposed accreditation standard. Such a direction could be, for example, that all accreditation standards must include a requirement that interprofessional education is an active and meaningful part of a curriculum.

Under s11(4), the Ministerial Council can give certain directions in relation to a proposed accreditation standard only under certain conditions. This raises two issues:

- Firstly, the legislation provides the power to direct in relation to a proposed accreditation standard, however, there appears no legislative requirement to give the Ministerial Council the opportunity to review any proposed standard prior to its approval by the relevant National Board and, once approved, the Ministerial Council has no authority.
- Secondly, the limitations on the Ministerial Council are that its consideration of an accreditation standard can only be relating to the recruitment and supply of health practitioners (focussing, for example, on such things as a unilateral decision to extend course length through a change to an accreditation standard) and that it must first give consideration to the potential impact of its direction on the quality and safety of health care.

Under s25 of the National Law, one of the functions of AHPRA is to establish procedures for the development of accreditation standards, registration standards and codes and guidelines approved by National Boards, for the purpose of ensuring that NRAS operates in accordance with good regulatory practice. Under this Section, the Agency Management Committee of AHPRA issued an instruction [Procedures for the development of accreditation standards](#) in 2014. The instruction included:

When a National Board considers, based on the accreditation authority's advice or its own analysis, that the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners, the National Board will advise the Ministerial Council of its view and the reasons for it so that the Ministerial Council can consider whether any action is required under s.11(4) of the National Law.

The National Board will not make a decision to approve (or not approve) the new or amended accreditation standard until the Ministerial Council provides its view to the Board.

It is noted that this procedural requirement only relates to where a National Board considers, in the first instance, that a proposed accreditation standard would trigger the provisions of s11(4a), although broader consultation requirements through HWPC in the development phase may provide the capacity to independently advise the Ministerial Council of potential issues.

In relation to the limitation on a potential Ministerial Council intervention to supply and recruitment questions only, the issue is whether this prohibits pursuing other key policy objectives around ensuring accreditation standards and processes actively support the relevance of, and institutional capability to deliver, health education which facilitates the development of a health workforce best suited to the community's future needs.

Issues

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?
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?

National workforce policy development

An important precursor to the provision of national workforce policy directions to the entities in NRAS is that there is a robust and formalised approach by which those directions are developed, debated and adopted.

A strong view advanced by many stakeholders was that AHMAC structures currently have that capacity and are uniquely placed to bring together jurisdictions, regulators and stakeholders to discuss those national reform directions, particularly through the HWPC. HWPC operates as a forum for all jurisdictions to reach agreement on key national health workforce issues requiring government collaborative action and provides advice on health workforce issues to Health Ministers.

In this context another COAG response to the recommendations of the Productivity Commission's report was the establishment of HWA in 2010. Whilst not replacing the functions of HWPC, it was provided with a number of statutory responsibilities including:

- Carrying out research and collecting, analysing and publishing data or other information for the purpose of informing the evaluation and development of policies in relation to the health workforce.
- Developing and evaluating strategies for development of the health workforce.

HWA was not a policy formulation body but a number of its activities demonstrated the value of a national focus on innovation and workforce reform that could complement reforms relevant to health education accreditation.

However, as part of the 'Smaller Government Reform Agenda', the Australian Government abolished HWA in 2014 and transferred its programs and functions to the Commonwealth Department of Health. A view advanced by some stakeholders is that AHMAC arrangements, whilst progressively enhancing engagement in this area, have yet to effectively replace the capability provided by HWA.

Consultations to date have offered the view that substantial benefit would be achieved if, in its planning processes, the HWPC was able to establish a regular component of its work program to include consideration of any educational reform matters needing to be progressed in relation to the functions of accreditation under NRAS as part of the overall workforce reform agenda.

Issues

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

In addition to the general regime described above, there is a unique element of the delivery of the accreditation functions in Medicine. This is the further devolution of the accreditation of medical specialist and pre-vocational medical education programs and training posts to the specialist colleges and state-based post graduate medical councils respectively. These bodies both accredit training posts and programs as well as being involved to various degrees in training program delivery. The Medical Board of Australia approves the assignment of those function based on advice from the Australian Medical Council. The actual approval of standards, general registrants, specialist registrants and specialist overseas practitioners, however, is through a direct relationship between the Medical Board and specialist colleges and post-graduate medical councils respectively.

It is understood that no funding is provided by the Medical Board to medical specialist colleges and colleges charge health services fees for assessing and accrediting training posts. In the case of the assessment of specialist overseas practitioners seeking specialist registration, the Review has been advised this is the subject of a letter of understanding between the Medical Board and the respective specialist colleges. In the case of post-graduate medical councils, it is understood the Medical Board provides funding for the performance of those functions.

As outlined in Section 1 the Medical Board and AHPRA have issued a request for quote from an external evaluation on the performance of the sixteen specialist medical colleges in relation to the assessment of specialist international medical graduates.

Given this, other work underway, and the time and resources available, the Review will consider decisions, processes and governance relating to function assignment, monitoring and reporting across the variety of accreditation arrangements and assessment of overseas practitioners but will not consider in detail specialist (Medical, Dental and Podiatry) and general medical international medical graduate assessments or intern accreditation operations and performance.

Questions for the Review in relation to these entities are thus focused on governance functions. Of particular interest is the extent to which accreditation standards developed by these bodies and their assessment processes are subject to public interest scrutiny, given that input requirements such as supervision, protected research time, etc. can have substantial impact on health service costs and delivery capability.

Issues

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

Assessment of overseas health practitioners

For overseas trained health practitioners seeking to practice in Australia, accreditation, registration and skills assessments are part of broader process that requires engagement with numerous organisations responsible for immigration, as well as state and territory governments, recruitment agencies and potential employers.

Skilled migration visas

To work as a registered health practitioner in Australia, it is necessary to gain registration through the relevant National Board. It may also be necessary to apply for a qualifications assessment for a skilled migration visa issued by the Australian Department of Immigration and Border Protection. Approved bodies to perform the skills assessment function for migration purposes for the relevant occupations is through gazettal by the Minister for Immigration, under the *Migration Act 1958*, *Migration Regulations*.

In a number of cases, National Boards make it clear that these two application processes are entirely separate and success in one does not automatically guarantee success in the other. For doctors, however, evidence of full registration is a suitable skills assessment for Points Tested Skilled Migration. Whilst not as explicit as Medicine, in some circumstances, other National Boards and the relevant accreditation authority, for example in Dentistry, have been able to achieve alignment of the assessment requirements and processes for both registration and skilled migration.

As outlined in Section 2, Part 6, Division 1, s42 of the National Law defines qualifications assessment for registration as accreditation functions as they relate to overseas practitioners as follows:

- Assessing ‘competent authorities’ in other countries to decide whether the examinations, programs of study conducted or accredited by the authorities provide the knowledge, clinical skills and professional attributes necessary to practise in Australia.

- Overseeing the assessment of the knowledge, clinical skills and professional attributes of individual overseas qualified health practitioners seeking to practise in Australia.

In terms of responsibilities, in some cases National Boards have chosen not to assign these functions to the respective accreditation council.

- **Nursing and Midwifery**, whilst the Australian Nursing and Midwifery Accreditation Council (ANMAC) has been gazetted as the skilled migration assessment body, the National Board is developing its own assessment process for purposes of registration. The National Board explains its decision to not align the two assessments on its website:

ANMAC takes into consideration work experience in assessing an applicant's qualifications, which is then used to determine suitability for skilled migration. Under the National Law, the NMBA can only take into account an applicant's qualifications when establishing whether their qualifications are substantially equivalent to an Australian qualification. This is why some applicants may be approved for skilled migration but do not meet the registration requirements of the Nursing and Midwifery Board of Australia (NMBA).

- For **Psychology**, the Australian Psychology Accreditation Council, whilst fulfilling NRAS accreditation functions, does not conduct accreditation of any individual's overseas qualifications. The assessment for registration is conducted by the National Board and skilled migration assessments are conducted by the Australian Psychological Society (APS).

It is understood that there have been ongoing discussion involving AHPRA, relevant National Boards, the Australian Department of Education and Training and the Australian Department of Immigration and Border Protection. However, the inappropriate conflating of registration and skilled migration assessments continues.

Issues

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?
33. Is there is 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?

Qualification assessment for registration

Overall, processes and responsibilities for this function vary by profession. As outlined in Section 1, given the time and resources available, it is intended that the Review will focus on decisions, processes and governance relating to function assignment, monitoring and reporting across the variety of accreditation arrangements and assessment of overseas practitioners, rather than the specific operational performance of the assessment processes for overseas practitioners or institutions for either general or specialist registration.

The Review has sought to map and understand the operation of assessment processes across the 14 professions and additional specialities within those professions. It is a diverse and often complex landscape. Initial observations include:

- Pathways and assessment techniques vary considerably across professions.
- There are differing approaches to progressing and applying overseas competent authority pathways between professions. This is reflected further in funding agreements where it appears that only four of the external accreditation councils were funded in 2015/16 for management and development of this function.
- There appear to be few assessment for registration pathways (including competent authorities) that lead to general registration, without either supervised practice requirements or undertaking exams (noting that applicants with New Zealand qualifications are covered by the Trans-Tasman Mutual Recognition Agreement).
- Appeal availability and processes are clear in some circumstances and not in others. It is also not clear whether an appeal should be related to the registration or the initial skills assessment decision.

Conscious of the complexity and variety of arrangements, the Review will continue to seek advice from National Boards and accreditation authorities to ensure systems are accurately analysed.

Issues

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?
35. 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?

Grievances and appeals

The NRAS Review observed that accreditation councils have different fee structures, different fee-setting methods, there is no standardised approach to accreditation and that there was currently little recourse for appeal of their decision-making processes in the Scheme. Recommendation 17 of the 2014 Review stated:

Amend the Health Practitioner Regulation National Law 2009 to provide that the National Health Practitioner Ombudsman has jurisdiction over accreditation functions

Subsequent to the 2014 Review, AHPRA and the HPACF released [Management of complaints relating to accreditation functions under the National Law – a guidance document](#) in May 2015. This establishes the scope of authorities as follows:

Where a complaint is received by an Accreditation Authority, the Accreditation Authority will consider whether the complaint:

1. *directly relates to an accreditation function under the National Law*

2. *is an issue that should be considered in the accreditation entity's monitoring processes under Section 50 of the National Law.*
3. *relates to compliance with the Quality Framework.*

If the complaint relates to one or more of the above issues, the Accreditation Authority will consider the complaint and respond to the complainant.

As noted in Section 1, the Ministerial Council accepted recommendation 17 in principle, advising it should be considered further following this Review of the accreditation processes. Given, however, the subsequent guidance document issued jointly by AHPRA and the HPACF, the Review is exploring whether circumstances have changed and what might be the most appropriate response to grievances and appeals.

Issues

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?
37. If an external grievance appeal process is to be considered:
 - Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
 - Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

Appendices

Appendix 1: Recommendations related to accreditation functions from the 2014 NRAS Review

Recommendation 14

Through the contractual arrangements between the Australian Health Practitioner Regulation Agency and the Accreditation Authorities, no fee increases levied on either National Boards or higher education institutions beyond the Consumer Price Index rate will be allowed without the express approval of the relevant National Board.

Recommendation 15

Through contractual arrangements between the Australian Health Practitioner Regulation Agency and Accreditation Authorities, standardised accreditation protocols and fee structures must be established within 12 months so that common accreditation processes can be adopted between all regulated health professions. These should be focused on education outcomes relevant to the outcomes of the National Registration and Accreditation Scheme not prescriptive education inputs

Recommendation 16

The standardised accreditation protocols should be the subject of consultation with higher education policy makers and providers to streamline accreditation processes and avoid duplication with existing university accreditation processes. This consultation should be sponsored by the Australian Health Practitioner Regulation Agency

Recommendation 17

Amend the Health Practitioner Regulation National Law 2009 to provide that the National Health Practitioner Ombudsman has jurisdiction over accreditation functions within the National Registration and Accreditation Scheme.

Recommendation 18

A standing committee is needed within the National Registration and Accreditation Scheme involving the education sector, National Boards, Accreditation Authorities and representation from employers and jurisdictions to:

- a. discuss the means by which health workforce reform and health service access gaps can be best addressed in the education and training of health professionals
- b. consider the evidence and value of alternative innovations in the delivery of health education and training. (An example is that simulated learning is accepted by some but not all accreditors)
- c. share an understanding of workforce distribution and projected workforce need.
- d. ensure that education opportunities exist for students to meet the minimum standard of entry

Recommendation 19

The fee structures for the accreditation functions associated with standard setting and assessment of overseas-trained health professionals and the accreditation of university programs of study should be clear and transparent as to which functions are funded by the National Boards from registrant fees and which are being met by the higher education sector. 8 Independent Review of the National Registration and Accreditation Scheme for health professions

Recommendation 20

The UK approach to accreditation should be explored to examine whether the significant cost difference between the UK and Australia results in better education outcomes in Australia. If this is not the case, then the UK approach to accreditation should be considered for application.

Appendix 2: Terms of Reference

The Review of Accreditation Systems will provide advice to AHMAC on the governance, structure, cost, and reporting arrangements to improve the efficiency, transparency and cost effectiveness of the health professions accreditation system, to support a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community.

The Review is to address:

- cost effectiveness of the regime for delivering the accreditation functions
- governance structures including reporting arrangements
- opportunities for the streamlining of accreditation including consideration of the other educational accreditation processes e.g. Tertiary Education Quality Standards Agency (TEQSA) and Australian Skills Quality Authority (ASQA)
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning
- opportunities for increasing consistency and collaboration across professions to facilitate integrated service delivery.

The advice to AHMAC and Health Ministers will include a report outlining options for reform of accreditation systems and structures. The final report will also include advice on any necessary legislative changes, and policy or administrative actions required to give effect to the preferred option/s and recommendations.

Appendix 3: Health Profession Accreditation Authorities

Aboriginal and Torres Strait Islander Health Practice Accreditation Committee

Australasian Osteopathic Accreditation Council

Australian and New Zealand Podiatry Accreditation Council

Australian Dental Council

Australian Medical Council

Australian Nursing and Midwifery Accreditation Council

Australian Pharmacy Council

Australian Physiotherapy Council

Australian Psychology Accreditation Council

Chinese Medicine Accreditation Committee

Council on Chiropractic Education Australasia

Medical Radiation Practice Accreditation Committee

Occupational Therapy Council

Optometry Council of Australia and New Zealand

Appendix 4: Australia's Health Workforce – Accreditation recommendations

Accreditation (chapter 6)

The Australian Health Ministers' Conference should establish a single national accreditation board for health professional education and training.

The board would assume statutory responsibility for the range of accreditation functions currently carried out by existing entities.

VET should be included as soon as feasible, although there are grounds for excluding it until the new arrangement is implemented and operating successfully in other areas.

Collectively, board membership should provide for the necessary health and education knowledge and experience, while being structured to reflect the public interest generally rather than represent the interests of particular stakeholders.

Initially, at least, the board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities should be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime.

The new national accreditation board should assume statutory responsibility for the range of accreditation functions in relation to overseas trained health professionals currently carried out by existing profession based entities.

References

Where documents referenced are freely available on the internet, a hyperlink to that document is provided in the body of the Discussion Paper. Where documents are not available, a detailed reference is provided below.

- Davis, D., Hercelinskyj, G., Jackson, L., (2016). Promoting Interprofessional Collaboration: A Pilot project using simulation in the virtual world of second life. *Journal of Research in Interprofessional Practice and Education* Vol 6.2.
- Dunston, R., et.al., (2016). *Curriculum Renewal in Interprofessional Education in Health: Establishing Leadership and Capacity*. Canberra, Commonwealth of Australia, Office for Learning and Teaching.
- Gaba, D.M., (2004). The future vision of simulation in healthcare. *Qual Saf Health Care* 2004;13(Suppl 1):i2-i10.
- Gruppen, L., Mangrulkar, R., Kolars, J. (2012). The promise of competency-based education in the health professions for improving global health. *Human Resources for Health* 10:43.
- Lawlis, T.R., Anson, J., Greenfield, D. (2014). Barriers and enablers that influence sustainable interprofessional education: a literature review. *J Interprof Care*, 2014; 28(4): 305-310.
- Leonard, M., Graham, S., Bonacum, D. (2004). The human factor: the critical importance of effective teamwork and communication in safe care. *Qual Saf Health Care*; 13(Suppl):i85-i90.
- McNair, R.P., (2005). The case for educating health care students in professionalism as the core content of interprofessional education. *Med Educ*, May; 39(5):456-64.
- Merga, M., (2016). Gaps in work readiness of graduate health professionals and impact on early practice: Possibilities for future interprofessional learning. *Focus on Health Professional Education: A Multi-disciplinary Journal*, Vol. 17, No. 3: 14-29.
- Smith, L. and Gallo, K., (2015) Building a culture of patient safety through simulation: an interprofessional learning model. New York: Springer Publishing Company.
- Solymos, O., O’Kelly, P., Walshe, C., (2015). Pilot study comparing simulation-based and didactic lecture-based critical care teaching for final-year medical students. *BMC Anesthesiology* (2015) 15:153.
- Stein, K.V., (2016). Developing a Competent Workforce for Integrated Health and Social Care: What Does it Take? *International Journal of Integrated Care*, 16(4):9, pp1-3.
- Stone, K., Patterson, M., Reid, J., Geis, G., Auerbach, M., (2016). Simulation to Improve Patient Safety in Pediatric Emergency Medicine. *Clinical Pediatric Emergency Medicine* 17(3):185-192.
- Veloski, J.J., Rabinowitz, H.K., Robeson, M.R., Young, P.R., (1999). Patients don’t present with five choices: an alternative to multiple-choice tests in assessing physicians’ competence. *Acad Med*. 74, 539-546.

Commissioned by the
Australian Health Ministers' Advisory Council for the



