

# Australia's Health Workforce: strengthening the education foundation



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

Final Report  
November 2017

## The Independent Review

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The Independent Reviewer, Professor Michael Woods, was appointed in October 2016 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.

Professor Woods is Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney and has Visiting Scholar status at Australian National University. Professor Woods has extensive experience in economics, the public sector and health policy. He was previously Commissioner, then Deputy Chair, of the Australian Productivity Commission during which time he presided on over 20 national policy inquiries and reviews. Professor Woods was also Under Treasurer for the Australian Capital Territory.

The Independent Reviewer was supported by a team comprising Peter Carver, Review Director, Praveen Sharma and Kate Weidemann.

The Independent Reviewer and the team would like to acknowledge and thank the many stakeholders and interested parties for their attendance at the consultation forums, submissions to the consultation documents and participation through other engagement activities. Your knowledge and feedback has contributed to informing the development of the Final Report and is gratefully appreciated.

The report is available at the Accreditation Systems Review project webpage at:  
<http://www.coaghealthcouncil.gov.au/Projects/Accreditation-Systems-Review>



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

30 November 2017

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Dear Mr Walsh

**Independent Review of Accreditation Systems - Final Report**

I am pleased to submit my Final Report on the Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions ('the Review').

Following a detailed analysis of the current accreditation system, this Report identifies opportunities to strengthen the education foundation of the health workforce by increasing the efficiency and effectiveness of accreditation functions and improving the relevance and responsiveness of health profession education.

Australia's health practitioners are well trained and renowned globally for the quality of care they provide. Accreditation authorities and education providers demonstrate a high level of goodwill in working collaboratively to ensure that training programs reflect contemporary practice. While these accomplishments are to be celebrated, the National Scheme must continue to mature. Its leadership must embrace a cycle of continuous improvement through sound internal processes as opposed to responding to scrutiny by reviews such as this.

The issues of high cost and duplication, and the lack of transparency, scrutiny and accountability, which have been identified during this Review are not new and there is a great deal of common agreement on what needs to be done. Fundamentally, the lack of timely implementation points to a failure of governance.

In proposing to reshape the governance arrangements, I have been cognisant of the inextricable link between the accreditation of health profession education and the registration of practitioners. The reform of one must retain a high level of trust by the other. Nonetheless, these two regulatory functions require different expertise and, at least in the case of accreditation, there needs to be a formal process by which cross-profession efficiency improvements and innovation can be driven. Within the constraints of my Terms of Reference, I have recommended the establishment of a national health education accreditation body to sit alongside the National Boards and to oversee accreditation functions. There will be system-level cost savings from these measures.

The maturity of national education regulatory schemes and health safety and quality systems has also provided new opportunities for removing unnecessary duplication of regulation and for more efficient and integrated delivery of functions based on expertise and consistency across both health and education.

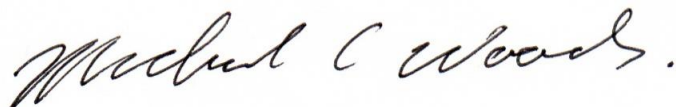
A further limitation of the current governance arrangements is the lack of an overarching health workforce policy which could provide national guidance to the accreditation system and to other regulatory entities within and outside the National Scheme. Agreement on such a policy would also provide invaluable guidance to education providers, professional associations and other stakeholders, so that all parties could work collaboratively for a flexible, responsive and sustainable health workforce that delivers safe, high quality care.

Through transmittal of this Final Report, I would like to take the opportunity to thank the many stakeholders who gave generously of their time, wisdom and evidence. I gratefully acknowledge the support of the Victorian Department of Health & Human Services in facilitating the project, as well as the participation from many professionals across the National Scheme and officials from jurisdictions and agencies.

I reserve my deepest gratitude for the Review team, led by Peter Carver, for their unstinting commitment to producing sound, evidence-based public policy which is firmly grounded in serving the public interest.

I thank AHMAC and the COAG Health Council for this opportunity and am available to brief AHMAC and Health Ministers on the Review and my recommendations.

Yours sincerely

A handwritten signature in black ink that reads "Michael C Woods." The signature is written in a cursive, flowing style.

**Professor Michael Woods**  
Independent Reviewer  
Accreditation Systems Review

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## Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ACDHS	Australian Council of Deans of Health Sciences
ADC	Australian Dental Council
AHMAC	Australian Health Ministers' Advisory Council
AHWMC	Australian Health Workforce Ministerial Council
AHPRA	Australian Health Practitioner Regulation Agency
AHSSQA	Australian Health Service Safety and Quality Accreditation
AISC	Australian Industry and Skills Committee
ALG	AHPRA Accreditation Liaison Group
AManC	AHPRA Agency Management Committee
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANAO	Australian National Audit Office
ANZCA	Australian and New Zealand College of Anaesthetists
ANZPAC	Australia and New Zealand Podiatry Accreditation Council
AOAC	Australasian Osteopathic Accreditation Council
APAC	Australian Psychology Accreditation Council
APC	Australian Pharmacy Council
APhysioC	Australian Physiotherapy Council
APRA	Australian Prudential Regulation Authority
AQF	Australian Qualifications Framework
ASIC	Australian Securities and Investments Commission
ASQA	Australian Skills Quality Authority
BAS	Business Activity Statement
CCEA	Council on Chiropractic Education Australasia
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CPI	Consumer Price Index
CPMC	Council of Presidents of Medical Colleges
CRIS	Cost Recovery Implementation Statement
DET	Commonwealth Department of Education of Training
DP	Submission to Discussion Paper
DR	Submission to Draft Report
FARMC	AHPRA Finance, Audit and Risk Management Committee
FOI	Freedom of Information
HCPC	Health and Care Professions Council
HPACF	Health Professions Accreditation Collaborative Forum
HPA	Health Professions Agreement

HWA	Health Workforce Australia
HWPC	Health Workforce Principal Committee
IPE	Interprofessional education
National Board(s)	National Health Practitioner Board(s)
National Scheme	National Registration and Accreditation Scheme
NHPOPC	National Health Practitioner Ombudsman and Privacy Commissioner
NMBA	Nursing and Midwifery Board of Australia
NRAS	National Registration and Accreditation Scheme
NSQHS	National Safety and Quality Health Service Standards
OCANZ	Optometry Council of Australia and New Zealand
OECD	Organisation for Economic Co-operation and Development
OTC	Occupational Therapy Council (Australia and New Zealand)
PMC	Postgraduate Medical Colleges
PSA	Professional Standards Authority
RACS	Royal Australasian College of Surgeons
RAF	Risk Assessment Framework
RIS	Regulatory Impact Statement
RTO	Registered Training Organisation
TPB	Tax Practitioners Board
TEQSA	Tertiary Education Quality and Standards Agency
UK	United Kingdom
USA	United States of America
USDET	United States Department of Education and Training
VET	Vocational education and training
WHO	World Health Organisation



# Executive summary



The Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (the Review) has been undertaken at the request of Health Ministers. In their August 2015 [COAG Health Council communiqué](#), Ministers expressed concerns about the high cost, lack of scrutiny, duplication and prescriptive approach to accreditation functions and believed that substantive reform was required to address these issues.

The Review has identified a broad range of opportunities to improve the efficiency and effectiveness of accreditation functions undertaken by accreditation authorities, National Boards and the Australian Health Practitioner Accreditation Agency (AHPRA) and to facilitate the greater relevance and responsiveness of health profession education. But these are not new discoveries. The problems and workable solutions can be found in previous reviews, in the deliberations of the Health Professions Accreditation Collaborative Forum (HPACF) and in submissions to this Review. There is a great deal of common agreement on what needs to be done, but equally there has been insufficient progress in pursuing reform.

*The single most important conclusion to be drawn from the Review is that the persistence of inefficient and ineffective accreditation processes, and of constraints to greater relevance and responsiveness of health profession education, are fundamentally failures of governance.*

Reform of the governance structure needs to address a range of complex and at times conflicting requirements. The challenges include:

- The National Scheme encompasses both the accreditation of health profession education and the registration of individuals as practitioners. They are inextricably linked and registration boards must have ongoing trust in the integrity of accreditation processes and decisions. And yet the two functions require different expertise.

*This Review argues for the separation of the two functions, each according to their expertise, but with procedures that maintain professional trust between them.*

- Profession-specific expertise is a fundamental underpinning for regulating accreditation (as it is for registration). And yet an accreditation system which comprises 14 separate accreditation authorities without a formal overarching structure is neither efficient nor effective. It will not produce an education foundation which promotes a flexible, responsive and sustainable health workforce that delivers safe, high quality innovative care which addresses the evolving needs of the community.

*This Review argues for an overarching national health education accreditation body of independent experts to drive reform.*

- The National Scheme is inward looking and focussed on the concerns of the professions. And yet the Scheme's objectives provide scope for more innovative service delivery and the recent reforms in the regulation of education and in safety and quality provide scope for greater efficiency and effectiveness

*This Review argues for the new governance structure to embrace these opportunities to ensure a more agile and engaged regulatory regime.*

- Finally, the multitude of entities operating within the National Scheme, and external bodies such as education providers, professional associations, employers and consumers are each setting their own directions and plans for the future. And yet there is no overall health workforce policy for Australia to guide them in a common direction.

*This Review argues that Health Ministers must oversee a review process which identifies health workforce policies and reforms that align workforce requirements with the health and social care needs of the community. Ministers should then periodically deliver a Statement of Expectations to National Scheme entities setting out reform directions and expectations about their roles and performance.*

Without governance reform there can be no assurance that the accreditation authorities, National Boards, AHPRA or its Agency Management Committee of AHPRA will deliver an actively regulated and managed accreditation system that supports the timely achievement of the National Law objectives.

## The Review in context

The National Registration and Accreditation Scheme (National Scheme) for health practitioners, established in 2010, is a unique and substantial achievement that consolidated 75 Acts of Parliament and 97 health profession boards into one National Law, 14 National Boards and 14 accreditation authorities for the registered professions, supported by a single administrative arm, the Australian Health Practitioner Regulation Agency (AHPRA). The Scheme has greatly improved the regulation of Australia's health workforce and contributed to its international reputation for delivering safe, high quality care to those in need. Despite this achievement, the Scheme remains a profession-based, complex and polymorphic governance arrangement with multiple overlapping regulators.

The National Scheme and its multitude of entities are guided by six National Law objectives. They include protecting the public through the registration of trained and qualified health practitioners, facilitating the provision of high quality health practitioner education and training, facilitating access to services in accordance with the public interest, enabling the continuous development of a flexible, responsive and sustainable health workforce and enabling innovation in the education of, and service delivery by, health practitioners.

The National Scheme has been established to serve the public interest, over and above the interests of the 14 registered professions. A central consideration for the Review, therefore, is how best the accreditation function could operate collectively and collaboratively with the registration function and the administrative arm of the Scheme to address the evolving health and care needs of the community. Australians are experiencing a growing burden of chronic disease, deep and persistent disadvantage, poorer health outcomes for those living in rural and remote Australia and for Aboriginal and Torres Strait Islander people, and growing numbers of frail aged. At the same time there are advances in technology and pedagogy and in research into health care treatments and health care system efficiencies. These issues create challenges and opportunities for determining the composition and structure of the future health workforce, the relevance and responsiveness of education and training, the development of innovative models of care and scopes of practice and the availability of the workforce across all spatial, cultural, financial and related areas of need.

The Review considers the National Scheme should embrace the significant regulatory reforms in education and health since 2010 which provide new opportunities to remove duplication and more efficiently deliver regulation based on expertise and consistency across both sectors. The developing national framework of safety and quality in health care similarly enables alignment of the regulation of health profession education and its accreditation with a whole-of-health system approach.

Given this context, the Review has adopted a threefold approach:

- To propose improvements to the efficiency and effectiveness of the current system.
- To remove the constraints in the current system to delivering more relevant and responsive health profession education programs that align with the National Law objectives and address health workforce priorities.
- To propose governance arrangements that will deliver the proposed reforms.
- Throughout its considerations, the Review has been ever mindful that the registration of individual health practitioners and the accreditation of health programs of study and providers are separate functions, each requiring their own expertise, but are also inextricably linked within the National Scheme. There must be procedures in place which maintain professional trust between the entities performing the respective functions.

## Improving efficiency and effectiveness

The cost of health care, including the workforce that delivers that care, is the greatest source of fiscal pressure on governments. The growing demand for aged care and disability care services is also placing increasing pressure on costs and on the availability of a skilled and accessible health and care workforce. In this context, a guiding principle for the education and utilisation of scarce health workforce resources was stated succinctly by AHMAC a decade ago to [Australia's Health Workforce](#) Productivity Commission Inquiry:

*"... wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care." (p14)*

The Review benefitted from an Accreditation Liaison Group (ALG) assessment of the expenditure of, and fees charged by, the 14 accreditation authorities. From this data and its own analysis, the Review concludes there is significant scope to introduce sound and fit-for-purpose processes by and across accreditation authorities which will reduce complexity and duplication, increase clarity and transparency, and reduce costs. The Review recommends the adoption of greater efficiency and commonality in accreditation standards, terminology, assessment processes, data collection and reporting requirements by, and across, the professions.

To rationalise the diversity of management and monitoring practices across the authorities, and to enable a cost-effectiveness assessment of the National Scheme and its component parts, the Review recommends the adoption of consistent and transparent accrual accounting and business standards. This will also assist in future benchmarking against broadly similar schemes in other countries.

There is also a need for a single set of funding principles to guide the setting of fees and charges for accreditation and the application of a transparent cost recovery policy and methodology. An appropriately scaled Cost Recovery Implementation Statement should be employed when setting fees and charges for accreditation activities.

The National Scheme needs to be more outward-looking, such as by pursuing opportunities to streamline processes that currently overlap with regulators operating outside the National Scheme. The education sector regulatory authorities (the Tertiary Quality Standards Agency (TEQSA) and the Australian Skills Quality Authority (ASQA), and the academic boards and similar bodies in self-regulating institutions) have different overarching purposes and foci for accreditation, but their underlying domains and processes intersect with the National Scheme regulators at the point of health profession education. Clarification and separation of roles and responsibilities should further reduce duplication, costs and administrative burdens, and adoption of findings by one regime from another would gain best value from the expertise held by each system.

### Delivering more relevant and responsive health profession education

The Review explored the constraints in the existing accreditation regulatory system to the delivery of more relevant and responsive health profession education programs that align with the National Law objectives and address health workforce priorities.

A threshold priority is to enhance service user involvement in accreditation functions to ensure a focus on patient-centred care. Broad-based consumer input (users, students and employers) can provide an important additional perspective to that of the professions and support more responsive and relevant health practitioner education. For consumer participation to be effective, however, there needs to be support and training so they can participate on an equal basis. Consumer involvement should be focussed on where it is most relevant, such as in the setting of accreditation standards and the design of programs of study.

There are opportunities for greater consistency and collaboration across professions which could facilitate more integrated and patient-centred care. These are not new insights, but neither have they been implemented systematically, consistently or cross-professionally. They include:

- adoption of outcome-based approaches for accreditation standards
- adoption of a common approach to the development of domains and learning outcomes for competency standards for professions by registration boards to ensure relevance to contemporary health care needs and to reflect workforce priorities including Cultural Safety.
- a common, cross-professional approach to the active support for interprofessional education in all accreditation standards and assessments
- a requirement that clinical placements occur in a variety of settings, geographical locations and communities, with a focus on emerging workforce priorities and service reform
- encouragement of innovative implementation of technological and pedagogical advances, such as simulation-based education and training, in the delivery of programs of study.

There is an ongoing debate about what ‘work-readiness’ means and the responsibilities of education providers and the accreditation system in this regard. There can be compelling rationales why some professions grant new graduates only a limited form of registration while they undertake supervised practice and, in some cases, require graduates to pass a separate examination before being granted full registration. However, the differences between the normal induction, orientation and mentoring provided by employers to assist new graduates and the requirements set by National Boards that restrict the attainment of general registration on first entry into the workforce need to be clarified. Accordingly, the Review is proposing that there be clearer

demonstration of the need for supervised practice and national examinations. The Review also considers that where National Boards require further vocational or academic education for the purposes of general registration, these requirements should be defined as programs of study and accredited by accreditation authorities.

## The argument for governance reform

The Report recommends a broad range of reforms which will improve the efficiency and effectiveness of accreditation functions and increase the relevance and responsiveness of health profession education. But these, by themselves, fall short of creating a fully functioning accreditation system. Previous reviews, the deliberations of the Health Professions Accreditation Collaborative Forum (HPACF) and submissions to this Review have identified many of the same problems and have proposed workable solutions.

However, while there is a great deal of common agreement on what needs to be done, equally there has been insufficient progress in it being done. The Review considers that this is fundamentally a failure of governance.

The current governance arrangements have shown themselves to be incapable of providing an actively regulated and managed accreditation system that delivers on all of the National Law's objectives in a timely manner. The governance is complicated by the number of entities involved and the powers they hold. The 14 accreditation authorities and the 14 National Boards all have accreditation powers, supported to varying extent by AHPRA. Accreditation functions are undertaken by specialist bodies and are generally within scope for the National Health Practitioner Ombudsman and Privacy Commissioner. Two national education regulators and a health safety and quality regulator have related functions. A further complexity is that the majority of accreditation authorities are private organisations and their oversight is either through commercial agreement or letters of assignment. Their functions are part of the regulatory framework but the governance and accountability arrangements are limited.

The Review has explored a range of governance issues and has developed a set of principles to guide its evaluation of options. At its most basic, there needs to be a collective and collaborative approach by all National Scheme entities to achieving the National Law objectives. Consumer involvement is paramount to ensuring the primacy of the public interest.

Regulatory responsibility should not be duplicative and decisions should be made by those with the appropriate expertise. This will require responsibility for the regulation of the accreditation functions under the National Law to be better defined and to be separated from that of the regulation of individual practitioners. The health profession accreditation bodies (currently the three accreditation committees and the 11 accreditation councils) would no longer report to the National Boards but to a cross-profession education accreditation body, as discussed under Option 2 below. Nonetheless, there must be procedures in place that maintain professional trust between the two regulatory groups.

Statutory decision making should be made independently of the regulated parties and other interested stakeholders. Any approach to ensuring the achievement of that independence should be largely agnostic as to the governance structures of accreditation councils, recognising the substantial contribution and expert professional input they make to accreditation. Additionally, all accreditation decisions should be transparent and be subject to statutorily prescribed scrutiny.

While there is a tendency for the National Scheme and its entities to be inward looking, the accreditation governance model must support a health workforce that is operating in a broader context where the regulated professions come together as health care teams and work with unregistered health professions and social services to respond to the evolving health and care needs of the community. These matters are addressed in the following examination of governance.

The Review has openly and transparently explored these issues with all interested parties by way of the Discussion Paper, forums in all States and Territories, the Draft Report, two rounds of submissions and other consultations. This Final Report examines, in the first instance, two broad governance options and then explores the preferred option in more detail.

## The first option

The Review's Option 1, similar to that set out in the Draft Report, is to enhance the role of an existing forum or liaison committee and strengthen other existing governance processes to streamline what the National Boards/AHPRA have referred to as the time-consuming and resource-intensive nature of the current arrangements.

The Review concludes that the existing bodies (the HPACF and the ALG) have fundamental limitations. They are not determinative bodies and lack the authority necessary to drive reforms to a timely conclusion. The functions have no mechanism to bring common matters together at decision-making points because the accreditation system and the National Scheme remain subject to individual decisions for the 14 regulated professions, either at an accreditation authority level or National Board level. This lack of a cross-profession locus of authority also puts at risk the collective reform of relationships and assignment of responsibilities with TEQSA and ASQA, and with ACSQHC on matters of safety and quality in competencies and curriculum.

Accordingly, the Review does not consider that there would be significant reform benefits under Option 1. However, irrespective of the future governance of accreditation functions, the Review recognises the important role that the HPACF plays in bringing together accreditation entities to enhance cooperation and progress common issues, and the role of the ALG in providing a forum for accreditation authorities and National Boards to pursue common interests. Continued collaboration will be critical, as will structured work programs and the provision of substantive resources to action the programs.

## The second option

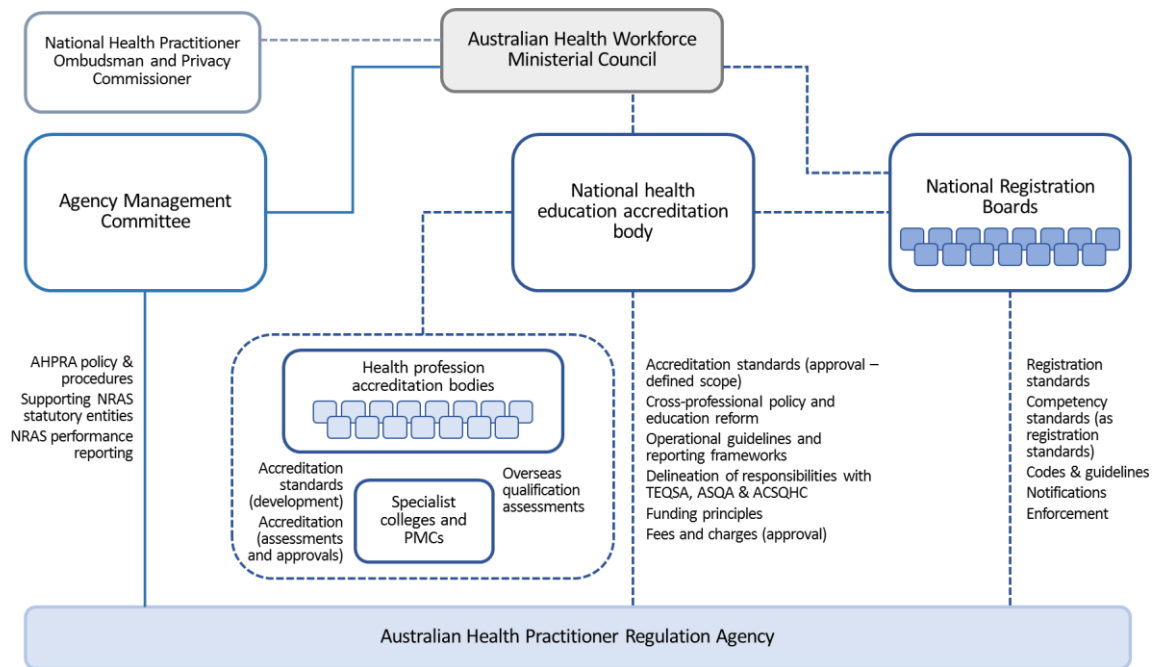
The Review's Option 2 is to establish a statutory national health education accreditation body within the National Scheme, with secretariat and policy capability drawn from AHPRA, to sit alongside the National Registration Boards. This body could be either an expert committee of the AManC or a separate national health education accreditation body, to whom the health profession accreditation bodies would report. In turn, National Registration Boards would have formal responsibility for competency standards to ensure the knowledge, skills and professional attributes of graduates of accredited programs of study meet their profession specific competency requirements for the purposes of registration.

While this option involves appointing a new body of accreditation experts, it would be the single point of approval of accreditation standards rather than the 14 individual National Board approval arrangements in the current National Scheme. Additionally, the national health education accreditation body would develop common policies and guidelines across education accreditation for the 14 professions, pursue greater interprofessional education and remove unnecessary overlap with TEQSA and ASQA processes. It would also remove the duplicative decision making by National Boards in the approval of programs of study by vesting that authority solely in the health profession accreditation bodies, provided the programs meet the accreditation standards.

With the aim of limiting the complexity of National Scheme governance, the Review is not averse to expanding the role of the AManC to take on the functions as outlined under this Option. However, such a decision should not be made in isolation of consideration of other broader governance matters that may arise from the current NRAS Governance Review. The configuration and skill mix of the AManC would also need to be reviewed to reflect its enhanced role.

There has been some concern that giving this function to the AManC effectively increases the reach of involvement, if not actual control, of AHPRA over the functions of the National Scheme. A counter to this, to some extent, is the current lack of an entity within the National Scheme which can be held accountable for the overall performance of the Scheme.

The Review considers, on balance that there is greater merit in establishing a separate statutory national health education accreditation body with responsibility for overseeing the accreditation function and the operation of the profession-specific accreditation authorities. The benefits include a dedicated and expert cross profession approach to accreditation whilst preserving the best features of current arrangements, improved reporting on performance, enabling a more direct focus on accreditation system efficiency and effectiveness, a locus of accountability for continuous improvement and clarity in function that avoids risks of being complicated and delayed by broader considerations of overall National Scheme governance.



The Review has identified the range of cost savings that are predicted to arise from its recommendations, noting that they are unlikely to be realised in a timely manner without governance reform. The Review has also costed the establishment of the governance proposals and concludes that there will be net savings to the Scheme as it is progressively implemented.

### Further opportunities to streamline processes and create efficiencies

A number of submissions raised the opportunity provided by this Review to consider the inclusion of unregistered professions in the overall reform of accreditation of health profession education under the National Scheme. Unregistered professions currently operate outside of the National Scheme. The new governance arrangements need to be forward looking and cognizant of the broader context that takes account of interactions of all health care with social and other services in responding to community needs. Providing capacity to support the accreditation of the education of relevant unregistered professions is consistent with this view. Introduction of greater flexibility into the National Scheme could provide a foundation for further consistency across a range of health and social care professions and enable cooperative participation in the inclusion of common competencies.

For overseas trained health practitioners seeking to practise in Australia, accreditation, registration and skills assessments are part of a broader process that requires engagement with numerous organisations responsible for immigration, state and territory governments, recruitment agencies, National Boards, AHPRA and potential employers. The Review recommends that AHPRA lead the development of a whole-of-National Scheme approach to the assessment of overseas trained practitioners for skilled migration and professional registration and the national health education accreditation body lead the development of a more consistent approach to the assessment of overseas trained practitioners and competent authorities and pursue opportunities to pool administrative resources. Other recommendations include aligning additional supervised practise requirements for overseas trained practitioners with Australian trained practitioner requirements and bringing specialist college decisions on overseas trained practitioners under the coverage of the *Health Practitioner Regulation National Law Regulation 2010*.

The Review considers that all statutory decisions should be made transparently and be subject to appropriate regulatory oversight. Such is not the case currently, for example, for decisions made by councils to accredit programs of study. Accordingly, the Review recommends the appointment of the National Health Practitioner Ombudsman and Privacy Commissioner to review all specified decisions made by accreditation entities, postgraduate medical councils and specialist colleges and any designated entity exercising an accreditation function regarding an assessment of the qualifications of an overseas practitioner. Given the number and variety of entities in the National Scheme, it is proposed that the Ombudsman and Privacy Commissioner should progressively review all grievances and appeals processes and make recommendations for improvement where necessary.

## Setting national reform priorities

The Review has been concerned by the paucity of guidance to National Scheme governance bodies in relation to health workforce policies and broader health system reform priorities. While the Review's Terms of Reference focus on the accreditation system, setting policy guidance for accreditation entities in isolation is self-limiting. Such guidance should encompass the broader set of concerns that are shared by the National Boards, AHPRA, education providers, professional associations, employers and consumers and foster collective and collaborative action. The guidance should be future focussed and responsive to evolving community needs.

The Review proposes that the COAG Health Council oversees a policy review process to identify health workforce directions and reforms that align workforce requirements with broader health and social care policies. The policy reviews should be conducted independently of Government, be consultative, transparent and evidence-based, and make recommendations to government through a public report.

The Review also proposes that the COAG Health Council (as the AHWMC) should periodically deliver a Statement of Expectations to AHPRA, the AManC, National Boards and the proposed national health education accreditation body that encompasses:

- national health workforce reform directions, including policies and objectives relevant to entities
- expectations about the roles and responsibilities of National Scheme entities, the priorities expected to be observed in conducting operations, and their relationships with governments
- expectations of regulator performance, improvement, transparency and accountability.

Finally, the Review proposes that AHMAC should work with AHPRA and other entities within the National Scheme to develop a set of clear, consistent and holistic performance indicators that underpin the response to the Statement of Expectations. In this manner, the National Scheme can be more fully held to account by governments and by the community.



# Consolidated list of recommendations



## Funding and cost-effectiveness (Chapter 3)

1. Funding principles should be developed to guide accreditation authorities in setting their fees and charges. The funding principles should:
  - a. be founded on transparency, accountability, efficiency and effectiveness
  - b. establish the full cost of accreditation functions performed by National Scheme entities (including the development of standards, policy advice, joint cross-professional accreditation activities, accreditation and assessment functions)
  - c. include a cost recovery policy and cost allocation methodology to guide the allocation of costs between registrants (through National Boards) and education providers
  - d. establish a consistent (accrual) accounting methodology and business principles to enable comparison across professions
  - e. require the development of a proportionately scaled Cost Recovery Implementation Statement when setting or reviewing fees and charges for accreditation activities.
2. The funding principles should be subject to wide stakeholder consultation, be submitted to the Australian Health Workforce Ministerial Council for approval and form the basis of funding agreements.
3. A set of clear, consistent and holistic performance and financial indicators for the National Scheme should be developed for approval by Australian Health Workforce Ministerial Council. They should be both quantitative and qualitative and reported on a regular and formal basis to promote continuous improvement.

## Improving efficiency (Chapter 4)

4. Cross-profession policies and guidelines for the development of accreditation standards and the conduct of assessment processes should be established to require:
  - a. Standardised terminology and definitions across the accreditation process
  - b. Agreed cross-professional domains and elements, in addition to existing profession-specific requirements, for inclusion within standards
  - c. A common reporting framework that sets out uniform requirements for education providers and includes consistent risk indicators, standardised data collection and collaborative use of information technology approaches.
5. Clarification of academic and professional accreditation should be agreed between education sector regulators, institutional academic governance bodies and health profession accreditation authorities. Implementation should be achieved through mutual recognition of the respective roles and responsibilities of regulators, adoption of accreditation findings and outcomes from recognised regulatory processes, appropriate sequencing of accreditation processes and improved data sharing.



6. Cross-profession policies and guidelines should be established to improve the quality and performance of accreditation assessment teams through:
  - a. a standardised approach to their training and preparation
  - b. a self-assessment or peer review process for monitoring their performance
  - c. a common approach to their remuneration.

### Relevance and responsiveness of education (Chapter 5)

7. Accreditation standards should include a consistent requirement that education providers demonstrate the involvement of consumers in the design of education and training programs, as well as demonstrate that the curricula promote patient-centred health care.
8. AHPRA should expand the Terms of Reference for the AHPRA Community Reference Group to include accreditation functions and enable accreditation authorities to refer issues to the Group for advice.
9. Accreditation authorities should focus on outcome-based approaches when developing new, or revising existing, accreditation standards. Where input or process based indicators are deemed necessary, they should be justifiable, non-restrictive and consistent with achieving the National Law objectives.
10. National Boards should develop, and recommend to the Australia's Health Workforce Ministerial Council, profession-specific competency standards formally under the National Law in accordance with the legislative provisions established for the development of registration standards. Competency standards should be developed cooperatively through wide-ranging consultation to achieve:
  - a. standardised definitions and terminology
  - b. agreement on those competencies that are common to all health professions and profession-specific performance criteria and indicators
  - c. inclusion of specific and consistent references to:
    - i. NSQHS Standards for quality and safety, including collaborative practice and team-based care, developed in partnership with the Australian Commission on Safety and Quality in Health Care
    - ii. cultural safety and Aboriginal and Torres Strait Islander health developed in partnership with the National Scheme's Aboriginal and Torres Strait Islander Health Strategy Group
  - d. alignment with service models and responsiveness to national health workforce priorities that best serve evolving community health care needs.
11. Accreditation authorities in their development of accreditation standards, and National Boards in their development of competency standards, should use agreed definitions for interprofessional learning and practice. This should be supported by guidance material, developed through broad consultation, which clarifies expectations of education providers and outlines a competency-based assessment approach that focuses on facilitating team-based practice and collaborative care.
12. Accreditation authorities should, within an outcome-based approach to accreditation standards and assessment processes, encourage:
  - a. clinically-relevant placements to occur in a variety of settings, geographical locations and communities, with a focus on emerging workforce priorities and service reform
  - b. evidence-based technological advances in the curricula and pedagogical innovations in the delivery of programs of study.

13. National Boards that wish to set requirements for general registration additional to domestic qualification attainment should:
- a. demonstrate the requirements of postgraduate competencies required at profession-entry level that can be differentiated from normal and expected progressive work experience
  - b. provide evidence that the approved accreditation standard is unable to ensure delivery of the knowledge, skills and professional attributes necessary to practise the profession, even after amendment
  - c. establish and document whether there is a requirement for supervised practice or vocational training and specify the expected learning outcomes and how they will be assessed
  - d. specify if the supervised practice or vocational training warrants a category other than general registration and the limitations of that registration.
14. If National Boards set requirements for general registration additional to domestic qualification attainment that require further vocational or academic education, these requirements should be defined as programs of study and accredited by accreditation authorities.

### Accreditation governance – foundation principles (Chapter 6)

15. Governments should separate responsibility for the regulation of the accreditation functions under the National Law from that of the regulation of individual practitioners. The governing entities of the two functions should operate collaboratively to achieve all objectives of the National Scheme.
16. A health profession accreditation body for each regulated profession (being the current accreditation authority for at least the first five years) is to be assigned to undertake the accreditation functions described in s42 of the National Law as amended as follows:
- a. Development of accreditation standards for approval (see Recommendation 19)
  - b. Approval of programs of study and education providers which meet approved accreditation standards and provide a qualification for the purposes of registration
  - c. Approval of any action required as identified in the monitoring of programs of study and providers which meet approved accreditation standards
  - d. Approval of authorities in other countries which conduct examinations for registration in a health profession, or accredit programs of study and approval of those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia
  - e. Approval of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession, and advice of the assessment outcome to the relevant National Board.
17. The governance of a health profession accreditation body should be structured to ensure the body achieves the following in the accreditation of health profession education:
- a. It must place the public interest foremost and apply professional and other expert input to decision-making that is in accordance with National Scheme objectives
  - b. It exercises its decision-making independently of regulated parties and other interested stakeholders
  - c. Its decisions should be transparent and subject to the same grievance and appeals requirements as decisions made by other National Scheme entities (as described in Recommendation 31)
  - d. The governance structure of an accreditation body must enable it to operate effectively in either an external private entity or under the auspices of AHPRA, the statutory agency, but not have its decisions subject to approval or undue influence by their governing bodies.

18. Governance arrangements must be designed to be able to support potential future amalgamation of health profession accreditation bodies for efficiency and effectiveness purposes should such amalgamation be agreed.

### A governance model for more efficient and effective accreditation (Chapter 7)

19. Governments should establish in the National Law a national health education accreditation body with the following responsibilities:
- a. Assignment of accreditation functions to health profession accreditation bodies either individually or, where agreed, to amalgamated bodies, in accordance with Recommendations 16,17 & 18
  - b. Collaboration with other National Scheme entities to design and implement the operational interface between accreditation and registration
  - c. Determination of policies, principles, guidelines and reporting requirements, as appropriate, in relation to Recommendations 1, 3, 4, 5, 6 & 7
  - d. Approval of fees and charges proposed by health profession accreditation bodies in accordance with Recommendation 1
  - e. Development and management of the overall relationships with TEQSA (and the academic boards of self-accrediting higher education institutions) and ASQA, in accordance with Recommendation 5, including agreements with those regulators that encompass the following parameters:
    - i. Institutional academic accreditation to be undertaken by TEQSA-approved structures for higher education providers or ASQA-approved structures for Registered Training Organisations.
    - ii. Professional accreditation to be undertaken by accreditation authorities
  - f. Approval of accreditation standards developed in accordance with its policies and guidelines.
  - g. In partnership with the ACSQHC, determination of the elements of the NSQHS Standards that should be incorporated into the accreditation standards and the elements that should be recommended to National Boards for inclusion in professional competency standards
  - h. In partnership with ACSQHC, exploration of the potential to include a module within ACSQHC accreditation regimes that encompasses the health service elements of the clinical education/experience domain in professional accreditation.
20. If Governments determine that the functions of the national health education accreditation body should be conducted by the Agency Management Committee, they should ensure that:
- a. Any decision should not be made in isolation of consideration of other broader governance matters and should ensure there is clarity in roles assigned across all National Scheme entities.
  - b. Enhanced and comprehensive reporting systems and measures are put in place to provide a transparent platform for performance monitoring and continuous improvement.
  - c. The configuration and skill mix of the Agency Management Committee is reviewed to reflect the enhanced role and, if the model to be adopted is one where the Agency Management Committee delegates this role to a standing committee:
    - i. the process for selecting members for that committee should be transparent and the committee must provide decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders
    - ii. the committee must place the public interest foremost and provide complete transparency in decision making.

21. A National Board may request a health profession accreditation body to review a decision to accredit a program of study as follows:
  - a. The request for review must be based on the National Board's opinion that the program of study would not deliver practitioners with the necessary knowledge, skills and professional attributes in accordance with formally approved profession-specific competency standards. In seeking that review, the National Board must specify where in the program of study it considers there are deficiencies.
  - b. The health profession accreditation body must review that program of study against the deficiencies identified by the National Board and either confirm, change its decision or require changes to the program of study to rectify any deficiencies. The health profession accreditation body must provide a report back to the National Board on its assessment and how any deficiencies identified by the National Board have been dealt with.
22. The national health education accreditation body should invite current accreditation authorities to establish health profession accreditation bodies for the initial five-year period.
23. Following the initial five-year period, the national health education accreditation body should seek expressions of interest and assign profession specific accreditation functions for periods of five years.
24. Governments should ensure the National Law does not prohibit the future limited participation of unregistered health and social care professions through access to the skills and expertise of the accreditation regime and operation of their accreditation activities with its support, subject to the following conditions:
  - a. Participation should be subject to COAG Health Council approval and consultation with stakeholders
  - b. Unregistered professions participating in the accreditation provisions of the National Law would be identified as being in a separate category to the registered professions.
  - c. Accreditation activities undertaken by unregistered professions would have no implications for the registration of that profession. All applications for registration would continue to be dealt with through established COAG Health Council processes and in accordance with the COAG agreed criteria.

### Other governance matters (Chapter 8)

25. AHPRA, in partnership with the national health education accreditation body, health profession accreditation bodies and National Boards, should lead discussions with the Department of Education and Training and the Department of Immigration and Border Protection to develop a one-step approach to the assessment of overseas trained practitioners for the purposes of skilled migration and registration and pursue other opportunities to improve system efficiencies.
26. The national health education accreditation body, in collaboration with National Boards, health profession accreditation bodies and specialist colleges, and other stakeholders should establish policies and guidelines for:
  - a. international course accreditation
  - b. qualification assessments and supervised practice requirements for overseas trained practitioners, aligned with Australian trained practitioner knowledge, skills and professional attributes requirements.
27. The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners. This includes working in partnership with the Medical Board of Australia on the development of agreed performance indicators and reporting metrics that are appropriate, comparable and aligned with other relevant National Scheme reporting regimes, in terms of time periods, cost effectiveness and the ability to trace assessment pathways from application to registration.

28. Specialist colleges should ensure that the two pathways to specialist registration, namely:
- being assessed by a specialist college and passing the requirements for the approved qualification, or
  - being awarded a fellowship of a specialist college
- are documented, available and published on specialist college websites and the necessary information is made available to all prospective candidates.
29. Accreditation entities and their functions should be subject to the same requirements as all other decision-making entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner in reviewing administrative actions relating to:
- a. health profession accreditation bodies in relation to programs of study and education providers of those programs
  - b. postgraduate medical councils and specialist colleges in relation to the accreditation of training posts/sites
  - c. any designated entity undertaking an assessment of the qualifications of an overseas trained practitioner (including specialist colleges).
30. The National Health Practitioner Ombudsman and Privacy Commissioner should review the grievances and appeals processes of entities as defined in Recommendation 29, with the view to making recommendations for improvement by each entity where it considers the processes to be deficient.
31. The COAG Health Council should oversight a policy review process to identify national health workforce directions and reform that:
- a. aims to align workforce requirements with broader health and social care policies that respond to evolving community needs
  - b. engages regulators, professions, consumers, service providers and educators.
  - c. is approached in a robust, formalised and evidence-based manner in a regular cycle to ensure currency and continuous improvement.
32. The Australian Health Workforce Ministerial Council should periodically deliver a Statement of Expectations encompassing all entities within the National Scheme that covers:
- a. key health workforce reform directions, including policies and objectives relevant to entities in the National Scheme
  - b. expectations about the role and responsibilities of National Scheme entities, the priorities expected to be observed in conducting operations and their relationships with governments
  - c. expectations of regulator performance, improvement, transparency and accountability.

# 1 The Review



This chapter sets out the background to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (the Review). It expands on the Review's Terms of Reference and provides information on its conduct.

## The National Registration and Accreditation Scheme

The National Registration and Accreditation Scheme (NRAS/the National Scheme) came into operation on 1 July 2010 (18 October 2010 in Western Australia) and was implemented through enactment of the Health Practitioner Regulation National Law in each state and territory. The Scheme commenced with national registration for 10 regulated health professions. On 1 July 2012, a further four professions joined the National Scheme and on 13 June 2017, a legislative amendment was introduced into the Queensland Parliament to include Paramedics as the fifteenth regulated profession.

The National Scheme was established following the Productivity Commission's 2005 report [Australia's Health Workforce](#). The report highlighted the fragmented arrangements for the registration of practitioners and accreditation of qualifying programs for entry to the professions. The report recommended a restructure of the governance arrangements and rationalisation of the multi-jurisdictional bodies, not only to lift standards and provide efficiencies, but also to provide the levers and incentives to drive workforce reform and innovation.

In relation to accreditation, the Productivity Commission recommended a national cross-profession approach, 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 existing arrangements while enabling improved workforce flexibility, increased consistency of course accreditation, reduced compliance costs, and greater interdisciplinary and multidisciplinary opportunities.

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

## Objectives and guiding principles of the National Scheme

The National Law (s3) identifies six objectives and three guiding principles for the National Scheme:

- 2) *The objectives of the national registration and accreditation scheme are —*
  - 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.*
- 3) *The guiding principles of the national registration and accreditation scheme are as follows—*
  - a) *the scheme is to operate in a transparent, accountable, efficient, effective and fair way;*
  - b) *fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;*

- c) *restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.*

An entity that has functions under the National Law is required to exercise its functions with regard to the six National Scheme objectives and the three guiding principles (s4).

## Scope of the Review

In 2014, the Australian Health Workforce Ministerial Council (AHWMC) commissioned an independent review of the National Scheme ([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 relating to accreditation functions but reported concerns about the high cost, lack of scrutiny, duplication and prescriptive approach to accreditation functions highlighted in the report. The August 2015 Council of Australian Governments (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”.*  
(p2)

Health Ministers asked the Australian Health Ministers’ Advisory Council (AHMAC) to commission a comprehensive review of accreditation functions. On 10 October 2016, AHMAC released a [communiqué](#) announcing the appointment of Professor Michael Woods as Independent Reviewer.

The Terms of Reference required the Review to address:

- the cost-effectiveness of the regime for delivering the accreditation functions
- governance structures, including reporting arrangements
- opportunities for streamlining accreditation, including consideration of other educational accreditation processes, for example, the 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 interprofessional learning
- opportunities for increasing consistency and collaboration across professions to facilitate integrated service delivery.

The Review’s Report to AHMAC and Health Ministers addresses these Terms of Reference within the context of supporting a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community. It examines options for the reform of accreditation systems and structures, and the legislative changes and policy or administrative actions required to give effect to the recommendations.

The Report has also taken into account the environment within which accreditation takes place, including its relationship with, and the functions of, other health system organisations. Accordingly, the Report makes recommendations on setting overall policy directions for Australia’s health workforce and issuing Statements of Expectations for the National Scheme’s entities and their functions.

## The concepts of efficiency and effectiveness

Central to this Review is an assessment of the efficiency and effectiveness of the accreditation system. Both concepts are enshrined in the National Law. For example, the National Law requires the Australian Health Practitioner Regulation Agency (AHPRA) to maintain an Agency Fund that has separate accounts for each National Board (s208). AHPRA and the National Boards must each *“ensure that its operations are carried out efficiently, effectively and economically”*, and that *“as far as possible, reasonable value is obtained for moneys expended from the Fund”* (s212(1)(a), s212(2)(a), s212(1)(c)).

The World Bank in its [Sourcebook for Evaluating Global and Regional Partnership Programs](#) defines **efficiency** as *“the extent to which the program has converted or is expected to convert its resources/inputs (such as funds, expertise, time, etc.) economically into results in order to achieve the maximum possible outputs, outcomes, and impacts with the minimum possible inputs”*. (p65) Chapter 4 examines the efficiency of the accreditation system along these lines, and presents proposals for minimising inputs, costs and duplication and to streamline processes.



The [Productivity Commission](#) (2013, p6) defines **effectiveness** as “*the extent to which stated objectives are met – the policy achieves what it intended to achieve*”. The Review has focused its effectiveness analysis on the six National Law objectives which guide both the Scheme as a whole and all of its component parts - including the accreditation functions. Chapter 5 explores gaps in the achievement of the objectives, and Chapter 7 provides proposals on how all objectives could be addressed in a balanced manner, both in terms of the policy framework for the National Scheme as a whole and the individual decisions taken by entities within it.

The concept of **cost-effectiveness** is more complex and there are many definitions and approaches. The World Bank, again in its Sourcebook for Evaluating Global and Regional Partnership Programs, defines it as “... *the extent to which the program has achieved or is expected to achieve its results at a lower cost compared with alternatives*”. (p65) Chapter 3 explores this and considers approaches that could facilitate ongoing robust assessments of the relative cost-effectiveness of accreditation systems.

## Related initiatives

The Review was aware of concurrent work undertaken by governments that was relevant to accreditation functions under the National Scheme. The Review factored this work into its deliberations and into the development of its recommendations.

- The **NRAS Governance Review**, has been exploring improvements to governance, reporting and reform arrangements within the National Scheme. While governance of accreditation functions is out-of-scope, there is potential for overlap due to interrelationships between accreditation and registration functions and the National Scheme generally.
- The decision to include paramedics into the National Scheme. The Review notes that the Paramedicine Board of Australia met for the first time on 30 October 2017 and the intention is that all paramedics in Australia must be registered with the Board in order to practise from late 2018. As far as is possible, the Review has sought to encompass the profession in its deliberations and is grateful for submissions received from stakeholders in this regard.
- Implementation of the [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.
- The Commonwealth Department of Education and Training commissioned PhillipsKPA to examine the extent and scope of professional course accreditation practices in Australian higher education. The [Professional Accreditation: Mapping the territory](#) final report has been released and will inform the Higher Education Standards Panel about opportunities to reduce the regulatory burden on higher education providers.
- The Medical Board of Australia has commissioned an external review of specialist medical colleges and their assessment of overseas trained practitioners. This is focussed on performance against identified measures and future monitoring. However, the review is limited to assessing the extent to which each college’s processes and procedures comply with the ‘[Good practice guidelines for the specialist international medical graduate assessment process](#)’ which were developed by the National Board.

## Limitations to the scope of the Review

The scope of the Review has been limited in the following areas:

- The Review focused on arrangements for currently regulated professions under the National Scheme. However, it has been cognisant of the fact that the National Scheme is dynamic and other professions may progressively be included or interface with those that are regulated. The Review has considered the impact of its proposed reforms on other health professions and recognised the benefit of greater collaboration across all health and care professions.
- The Review has not explored in detail specific accreditation decisions. It has, where relevant, referred to examples where they represent either best or poor practice in fulfilling the National Scheme objectives.
- Noting the concurrent NRAS Governance Review, the Review focused on matters relating to the governance of accreditation functions. It also considered matters relating to functions and powers of the Agency Management Committee (AManC) and National Boards regarding:
  - the impact of registration standards on education delivery mechanisms and inputs (Chapter 5)



- decisions, processes and governance relating to the assignment, monitoring, reporting and delivery of accreditation functions (Chapter 7)
- approaches to articulating health workforce reform priorities for action by National Scheme entities (Chapter 8).
- Given other work underway, and the time and resources available to the Reviewer, the Review considered decisions, processes and governance relating to function assignment, monitoring and reporting across the variety of accreditation arrangements and assessment of overseas practitioners, but has not considered in detail:
  - specialist and intern accreditation operations and performance
  - operational performance in assessing overseas practitioners for 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 (NRAS Review recommendations 24 and 25). The Medical Board of Australia has also advised that it has commissioned an external review of specialist colleges. Further information is available in Chapter 8.

## Review process

The Review has undertaken research and analysis of current evidence and data as well as information contained in submissions and other stakeholder feedback. It considered previous reports related to the National Scheme and health workforce regulation, and submissions to this Review and the NRAS Review. Further research and analysis was undertaken into national and international best practice for accreditation systems and health workforce education and development.

Stakeholder feedback was sought through both targeted and broad-based consultation approaches. This included a communication strategy, a two-stage open consultation process, and direct engagement with a range of interested parties including representatives from:

- AManC and AHPRA
- National Boards
- accreditation authorities (councils and committees)
- health education providers
- health consumers
- government departments from all jurisdictions
- agencies including TEQSA, ASQA and the Australian Commission on Safety and Quality in Health Care (ACSQHC)
- AHPRA advisory groups (Aboriginal and Torres Strait Islander Health Strategy Group, Community Reference Group and Professions Reference Group)
- health service providers
- health professional associations.

The first stage of the public consultation process commenced with the release of a Discussion Paper on 27 February 2017. Consultation forums were held in the capital city of each Australian state and territory during March 2017 to provide stakeholders the opportunity to discuss the topics and questions raised in the Discussion Paper. An additional forum for national organisations was held in Melbourne. A separate workshop was co-hosted with the Consumers Health Forum of Australia to seek consumer perspectives on accreditation processes and outcomes. Approximately 500 individuals attended the consultation forums, representing more than 200 organisations.

The Review also met with officials from TEQSA, ASQA, ACSQHC and the Commonwealth Department of Education and Training to discuss opportunities for a more streamlined and consistent approach to accreditation that could be better aligned with health service and education regulation more broadly. In addition, the Review requested specific information from AHPRA, National Boards and accreditation authorities on current processes. Where provided, this is referred to as 'information provided directly to the Review'.

The release of a Draft Report on 4 September 2017 commenced the second stage of public consultation for the Review.

The Review received 114 written submissions to the questions posed in the Discussion Paper, 118 written submissions to the draft options and recommendations in the Draft Report and held further discussions with stakeholders where it sought further clarification. Public submissions are available on the [COAG Health Council website](#).

The Review acknowledges and appreciates the comprehensive feedback it received from all stakeholders. This feedback has informed the Final Report for submission to AHMAC on 30 November 2017.

## Report structure

This Final Report is structured as follows:

**Chapter 1: The Review** provides background to the establishment of the Accreditation Systems Review and its links with the previous NRAS Review and the Productivity Commission report on Australia's Future Workforce. This chapter expands on the scope of the Review and its consultation processes.

**Chapter 2: The health profession accreditation system** is a summary of the accreditation functions established within the National Scheme. It includes background information on the broader regulation of the education system and the work undertaken by national education regulators (TEQSA and ASQA).

**Chapter 3: Funding and cost effectiveness** details the current funding arrangements, including the income received by accreditation authorities and the expenditure incurred. It examines opportunities to improve accountability and transparency, and reduce cost through the development of funding principles and performance reporting.

**Chapter 4: Improving efficiency** explores the development of accreditation standards and the execution of assessment processes. It evaluates options to improve the efficiency of accreditation processes and proposes a range of reforms to distinguish the role of National Scheme accreditation from the regulation and course accreditation functions undertaken by TEQSA, ASQA and academic boards.

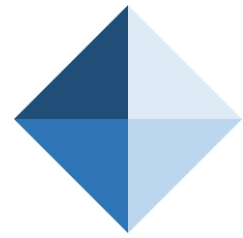
**Chapter 5: Relevance and responsiveness of education** explores the role of consumers in informing the effectiveness of the existing accreditation system. It examines the value of outcome-based accreditation standards, the role of professional competency standards, approaches to interprofessional education and practice and the relevance and quality of clinical placements. It explores the role of supervised practice and national examinations in the context of a system that already regulates the accreditation of health profession education.

**Chapter 6: Accreditation governance – foundation principles** establishes the principles of a fit-for-purpose governance approach. It considers separation of the regulation of the accreditation function from that of individual practitioners and the importance of recognising independence, transparency and expertise in decision-making.

**Chapter 7: A governance model for more efficient and effective accreditation** argues for governance reform to promote a more outward-focused, responsive and collaborative approach to accreditation that complies with the National Law guiding principles and delivers its objectives. The proposed approach provides a framework to reduce duplication, creates a locus of accountability for continuous improvement and aligns decisions with appropriate expertise.

**Chapter 8: Other governance matters** considers the role of specialist colleges, current processes for the assessment of overseas trained health practitioners, grievances and appeals mechanisms and the role of governments in setting health workforce reform directions that flow through to the National Scheme and to its entities and their functions, including that of accreditation.

## 2 The health profession accreditation system



This chapter sets out the role of accreditation within the National Scheme and the function of profession-specific accreditation in education and health regulation. It identifies synergies between accreditation functions undertaken as part of the National Scheme and those conducted as part of broader education and health service regulation.

### Key messages

Accreditation is a critical antecedent to registration. Accreditation provides the threshold assessment of education and training courses to assess whether graduates have the knowledge, skills and professional attributes necessary to practise the profession in Australia.

There are two broad categories of accreditation - academic accreditation and professional accreditation.

The current health professional accreditation system is a subset of the national process for the quality assurance and regulation of both the higher education and vocational education and training sectors.

Accreditation authorities are responsible for developing accreditation standards and assessing programs of study and education providers against these standards. A National Board can approve or refuse to approve the accredited program of study as providing a qualification for the purposes of registration in the health profession.

Accreditation functions include the assessment of authorities in other countries and the assessment of the knowledge, clinical skills and professional attributes of overseas health practitioners.

### What is accreditation?

Accreditation, in its broadest sense, is a quality and performance assurance mechanism designed to ensure that an organisation or program meets specified criteria, with those criteria often being set out in standards or frameworks.

The accreditation of health profession programs of study is a subset of the national process for the quality assurance and regulation of both the vocational education and training (VET) and higher education sectors. The Universities Australia and Professions Australia [Joint Statement of Principles for Professional Accreditation](#) (p2) defines two broad categories of accreditation:

- **Academic accreditation:** which refers to the evaluation of a course of study (either by TEQSA or by a self-accrediting provider such as a University) against course requirements specified in the Higher Education Standards Framework.
- **Professional accreditation:** which is intended to ensure that a course of study meets essential criteria in the training and education of its students in the relevant professional discipline, and that graduates from that discipline achieve the professional competencies and learning outcomes necessary for entry into the relevant level of professional practice.

As described further in Chapter 4, the academic and professional accreditation processes are complementary and interlinked.

## Academic accreditation

An education provider must meet the minimum acceptable requirements for the provision of education, and be registered by the relevant national regulatory agency, before it can deliver a program of study and bestow a qualification.

The [Australian Qualifications Framework](#) (AQF) is the national policy framework for regulating qualifications in the Australian education and training system encompassing higher education, VET and schools. The AQF provides an integrated approach to qualifications and qualification pathways and specifies the learning outcomes for each AQF level and qualification type, the requirements for issuing AQF qualifications, qualification linkages and student pathways, and alignment with international qualifications frameworks. In doing so, the AQF specifies how it applies to the accreditation and development of qualifications and aims to complement national regulatory and quality assurance arrangements for education and training.

### Higher education

In 2008, the Bradley Review of Higher Education recommended the development of a quality assurance framework for the higher education sector based on externally validated standards and rigorous performance measures. It further recommended the creation of an independent national agency with responsibility for all aspects of regulation. In response to the review, TEQSA was established, combining the scope of operations of the former Australian Universities Quality Agency and the state and territory government registration and accreditation authorities.

The functions and powers of TEQSA are outlined in s134 of the [TEQSA Act 2011](#). This includes the registration of higher education providers, accreditation of courses of study in accordance with the Act and the Australian Qualifications Framework and ensuring conformity with the Act through compliance and quality assessments. Section 41 of the *TEQSA Act (2011)* also allows TEQSA to authorise a registered higher education provider to self-accredit one or more courses of study, subject to meeting criteria outlined in the *Higher Education Standards Framework (Threshold Standards) 2015*.

Higher education providers classified by TEQSA in the 'Australian university' category have self-accrediting authority status. A majority of approved programs of study within the National Scheme are delivered by Australian universities. Programs of study delivered by higher education providers that do not have self-accrediting authority are assessed by TEQSA against the Threshold Standards. A course can be accredited for a maximum of seven years. For professions under the National Scheme, some Chinese medicine and nursing programs of study are delivered by higher education institutions that do not have self-accrediting authority.

As specified in Section 6.3 of the Threshold Standards, all higher education providers (self-accrediting and non-self-accrediting) must have academic governance processes and structures to assure the quality of programs of study. TEQSA's Guidance note on [Academic Governance](#) defines this governance as *"the framework of policies, structures, relationships, systems and processes that collectively provide leadership to and oversight of a higher education provider's academic activities (teaching, learning and scholarship, and research and research training if applicable) at an institutional level"*. (p1)

Continuous improvement is an important aspect of quality assurance as recognised in Section 5 of the Threshold Standards. In particular, Section 5.1 on course approval and accreditation requires that all courses are subject to a strict internal approval processes which, as described in TEQSA's Guidance note on [Academic Quality Assurance](#) requires that this occurs *"at arm's length from those involved in delivery of the course of study"*. (p2)

### Vocational education and training

In February 2011, COAG took significant steps in endorsing the [Intergovernmental Agreement for Regulatory Reform of Vocational Education and Training](#). The objectives were to streamline regulation, increase consistency across states and territories, and address quality concerns. This included a referral of powers to the Commonwealth from most states (except Victoria and Western Australia) and exercise of the Commonwealth's constitutional powers in regulation of VET in the territories.

The agreement provided the framework for national VET regulation, including the establishment of the ASQA, as defined in s155 of the [National Vocational Education and Training Regulator Act 2011](#) and the National Skills Standards Council. This new regime is underpinned by the *National Vocational Education and Training Act 2011*, related legislation and a range of standards in the VET Quality Framework.

This was followed by further COAG agreed reforms aimed at ensuring industry involvement in policy development and oversight of performance, and that governance arrangements and committees were streamlined. This resulted in the creation of an industry-led body, the Australian Industry and Skills Committee (AISC), supported by specific Industry Reference Committees.

Nationally recognised VET qualifications are included within National Training Packages which are developed through a process of national consultation. The most recent Health Training Package was approved by AISC in June 2016. These Training Packages include units of competency and qualifications to meet the needs of an industry or group or industries. They are developed and validated by Skills Service Organisations in consultation with industry stakeholders and are then endorsed by the Australian Government and state and territory governments for use nationally.

Registered professions with qualifications included in the Health Training Package include Aboriginal and Torres Strait Islander Health Practitioners, Dental Practitioner (Dental Prosthetics) and Nursing (Enrolled Nursing). Only one VET accredited course/approved program of study leading to registration under the National Scheme (the Advanced Diploma of Oral Health [Dental Hygiene]) is currently not included in the Health Training Package. However, the Dental Industry Reference Committee in its [Industry Skills Forecast](#) has identified the need for a nationally recognised Oral Health qualification to reflect the role of dental hygienists. This has been proposed for inclusion on their future work program.

Where a program of study is included within a National Training Package, ASQA does not specifically accredit the program but monitors the performance of the Registered Training Organisation (RTO) through annual reporting requirements outlined in the full Australian Vocational Education and Training Management Information Statistical Standard.

## Professional accreditation

Under the National Scheme, accreditation is a critical antecedent to registration. Part 6, Division 1, s42 of the National Law defines five accreditation functions.

- a) *developing accreditation standards for approval by a National 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 (and registration) standards

Health profession accreditation processes are aimed at ensuring compliance by education providers with accreditation standards, which are defined in s5 of the National Law in the following terms:

**Accreditation standard**, for a health profession, means a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.

This can be contrasted with registration standards which apply to individual practitioners and, as noted by [AHPRA](#) “define the requirements that applicants and registrants need to meet to be registered”. As specified in s38 of the National Law, each of the 14 National Boards must develop five core registration standards that address:

- professional indemnity insurance
- criminal history

- continuing professional development
- English language skills
- recency of practice

Section 38(2) enables National Boards to develop and recommend to the Ministerial Council additional registration standards about other matters relevant to the eligibility of individuals for registration and their suitability to competently and safely practice the profession. Section 38(3) refers to the distinction between registration and accreditation standards, stating that “a registration standard may not be about a matter for which an accreditation standard may provide”.

The arrangements for the development and approval of accreditation standards are provided for under s46 and s47 of the National Law, empowering National Boards to approve accreditation standards and publish them. In addition, under s11(4), the AHWMC may give direction to a National Board if, in its opinion, a proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners. AHWMC, however, may not provide directions in relation to individual programs of study.

As specified in s25(c) 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 the national registration and accreditation scheme operates in accordance with good regulatory practice”.

In November 2014 AHPRA issued [Procedures for the development of accreditation standards](#). This document reiterates the National Law provisions relating to the development and approval of accreditation standards and advises that accrediting authorities should take into account the COAG Principles for Best Practice Regulation when developing them. It also outlines how to operationalise s11 of the National Law which provides that the Ministerial Council may give directions to a National Board about a proposed accreditation standard.

## Accreditation assessments

As outlined in s49 of the National Law, a National Board can approve or refuse to approve the program of study as providing a qualification for the purposes of registration in the health profession. A National Board may also approve a program subject to any conditions it considers necessary.

Following passage of the National Law, AHPRA, the National Boards and the Health Professions Collaborative Forum spent some time designing a consistent operational interface between National Boards and accreditation authorities. for decisions relating to the accreditation and monitoring of programs. In 2012 they published a reference document, [Accreditation under the National Law Act](#), which sought to clarify the various responsibilities. In 2015 AHPRA also issued a [guidance document](#) on the approval of standards and programs of study. It defines the decision-making hierarchy as follows:

*“The National Board does not make the accreditation decision, that is, it does not assess the evidence and decide if the program and provider meet or substantially meet the accreditation standards. It does however use the Accreditation Authority’s report on the accreditation to make a decision on approval of the accredited program”.* (p3)

Whilst the guidance document does not articulate on what basis a National Board might approve or not approve a program of study, or what expertise the National Board should have to make such a decision, it does give some indication about matters to be considered by specifying the types of information an accreditation authority must or should provide to assist the National Board: This is discussed in detail in Chapter 6.

The AHPRA reference document (p20) plots the decision-making process from where an accreditation assessment has been completed by an accreditation authority as illustrated in Figure 2.1.



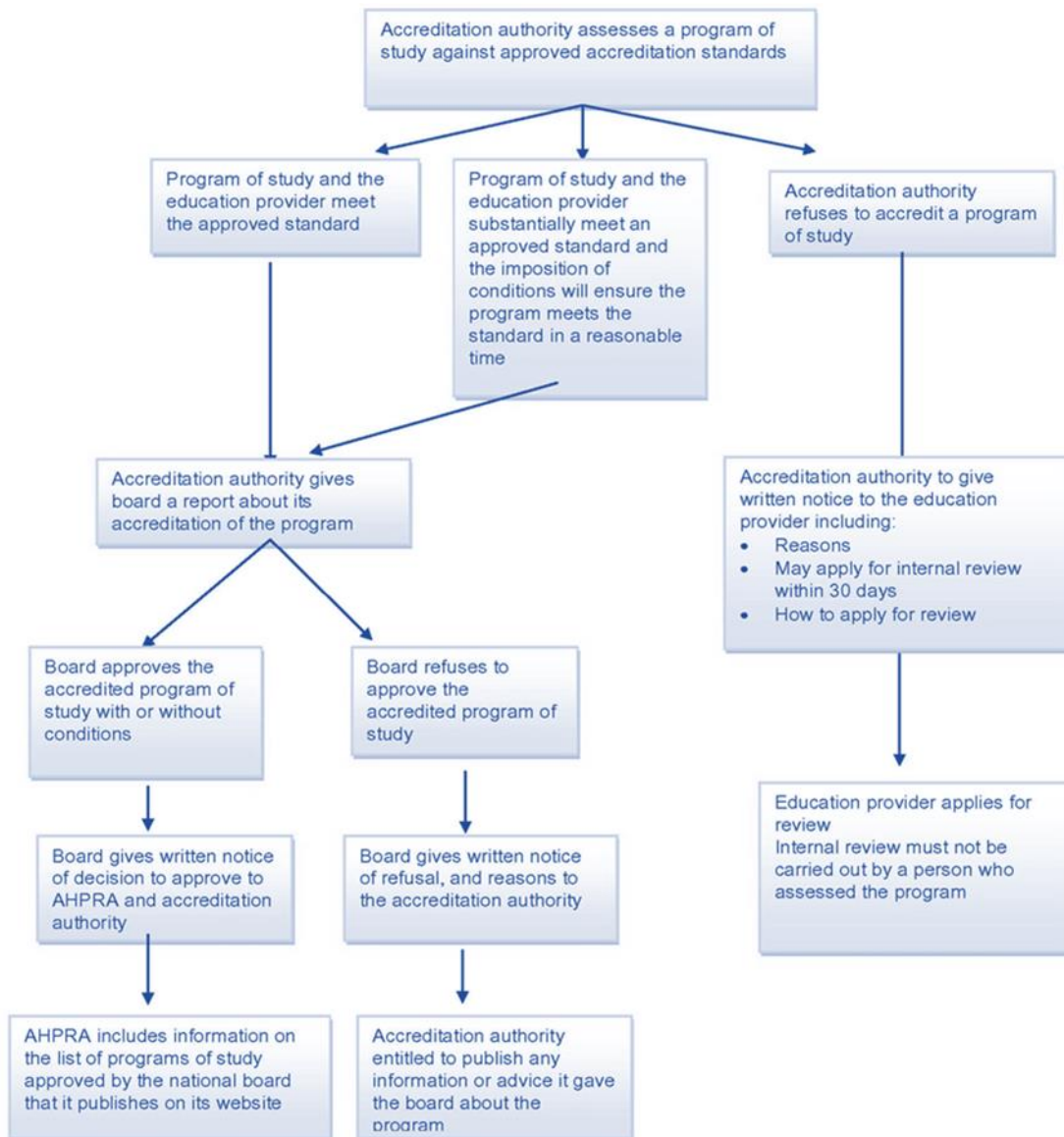


Figure 2.1. Accreditation under the Health Practitioner Regulation National Law Act - National Law provisions on accreditation of programs of study

Accreditation authorities are also responsible for monitoring approved programs of study and the education providers to ensure they continue to meet the approved accreditation standard (s50). Under s51, National Boards may impose conditions or cancel approval of programs of study based on advice from accreditation authorities and in addition, if an accreditation authority revokes accreditation, the National Board's approval is taken to have been cancelled at the same time.

## Accreditation and specialist registration

Prior to the introduction of the National Law, the Commonwealth Minister for Health and Ageing had the decision-making power to, firstly, recognise a new medical specialty or sub-specialty and, if necessary, approve an amendment to the [Health Insurance Regulations 1975](#). The first component of this recognition was for organisations who wished to have specialist medical skills and knowledge acknowledged and accepted as the standard for a particular area of practice. This form of recognition had no legal status but had a clear impact on approaches to health care delivery. The second component enabled doctors with specific qualifications to attract a relevant Medicare benefit for services rendered.

In July 2010, accreditation of specialist medical education and training programs became mandatory under the National Law for the purposes of specialist registration and provided for the protection of specialist titles. This was an important privilege accorded under the National Law as specialist titles were not previously protected. The professions of medicine, podiatry and dentistry now have specialist registration categories.

The decision to recognise specialist titles for registration purposes currently rests with the Ministerial Council which has issued [guidance](#) on the recognition of specialities under the National Law. However, Ministerial Council decisions do not impact on eligibility for Commonwealth benefit programs such as the Medicare Benefits Schedule or the Pharmaceutical Benefits Schedule. Eligibility for these programs takes place under separate Commonwealth Government application and assessment processes.

There are 13 specialist categories within dentistry, one specialist category in podiatry and 23 specialist categories (and 63 fields of specialty practice) in medicine. Accreditation of specialist training programs and their providers is undertaken by the relevant accreditation authority for these three professions. The accreditation processes for approval of specialist programs of study and education providers is different for specialist colleges compared to universities. Specialist college programs are not required to comply with the Higher Education Threshold Standards as it does not lead to an award within the AQF. There are also direct relationships established between each National Board and each accredited specialist college. The accreditation and assessment processes for specialist colleges have a triple functionality. They effectively:

- Endorse the specialist college as an approved education provider of specialist training for the purposes of specialist registration. This process enables college specialist training programs (for the purposes of Fellowship) to be recognised as approved qualifications for practice in the specialty.
- Empower specialist college as an accreditation authority with the mandate to establish specialty specific accreditation standards against which training providers are assessed. This provides specialist colleges with the ability to accredit training sites or individual training posts which influences both workforce supply and the ability of health services (such as public hospitals) to provide specialist services.
- Authorise specialist colleges to undertake assessments of overseas trained specialists. This enables specialist colleges to establish processes to assess overseas trained specialists including the ability to charge fees and set additional education and supervised practice requirements for overseas trained practitioners seeking specialist registration in Australia.

Accreditation of specialist training programs is discussed in detail in Chapter 8.

## Governance arrangements

While the National Scheme consolidated state and territory regulators, the entities delivering accreditation functions, and their operations, remained largely unchanged. An important feature of the National Scheme is that the accreditation function is more than the activities of the accreditation authorities, with the more significant accreditation approval roles being retained by the National Boards and with AHPRA playing an increasingly significant facilitating role.

The National Law (s43) specifies that each National Board must decide whether its accreditation function will be exercised by an external accreditation entity (accreditation council) or a committee established by the relevant National Board. One of the primary differences between the two approaches is that an accreditation council is generally an independent not-for-profit registered company which enters into a contractual agreement with AHPRA (as agreed by the relevant National Board) to exercise the accreditation functions. An accreditation committee, however, is established by a National Board with secretariat support provided by AHPRA.

Eleven of the National Boards have assigned the accreditation functions to an external entity. The nine profession-specific accreditation councils that existed prior to 2010 have continued and the Australian and New Zealand Osteopathic Council and the Australian and New Zealand Podiatry Accreditation Council have subsequently been established. The National Boards for the remaining three regulated professions (Aboriginal and Torres Strait Islander health practice, Chinese medicine and medical radiation practice) decided to carry out their accreditation functions directly through internal accreditation committees.

The [Quality Framework for the Accreditation Function](#) (2013) was developed as the principal reference for National Boards and AHPRA to assess the conduct of functions by accreditation authorities. The Quality Framework cover eight domains:

- **Governance:** the authority effectively governs itself and demonstrates competence and professionalism in the performance of its accreditation role.
- **Independence:** the authority carries out its accreditation operations independently.
- **Operational management:** the authority effectively manages its resources.



- **Accreditation standards:** the 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 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:** the authority has defined its standards and procedures to assess examining and/or accrediting authorities in other countries.
- **Assessing overseas qualified practitioners:** 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 authority works to build stakeholder support and collaborates with other national, international and/or professional accreditation authorities.

Whilst entities have largely remained unchanged since 2010, the National Scheme did provide some fundamental shifts in decision making in accreditation functions. The provisions of the National Law established different roles and responsibilities than operated in relation to the accreditation activities of particular professions and in different jurisdictions. Prior to the National Scheme there were a mixture of arrangements:

- accreditation authorities with the authority to accredit programs of study
- accreditation authorities needing to submit programs of study to state and territory registration boards for approval
- approved programs of study being declared in regulation
- state and territory registration boards running in-house accreditation operations.

The governance arrangements for various accreditation functions and issues arising are discussed in detail in Chapter 6.

## Assessment of overseas trained health practitioners

Accreditation functions also cover:

- the assessment of authorities in other countries to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by those authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia
- the assessment of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession.

The National Law enables the assessment of overseas trained practitioners to be undertaken by both National Boards (s35(e)) and accreditation authorities (s42(c) and s42(d)). The classification of this assessment process as both a registration and an accreditation function is unusual, and largely reflected legacy arrangements in place in previous state and territory schemes. Both the Nursing and Midwifery Board of Australia and the Psychologist Board of Australia have determined not to assign that function and instead oversee it directly with the support of resources from AHPRA.

There is a high level of diversity between each profession according to who conducts these assessments, how they are undertaken and the available assessment pathways. There are also other assessment systems covering skilled migration requirements. Issues relating to these functions are discussed in Chapters 6, 7 and 8.

## Stakeholders in accreditation

Consistent with the eighth Domain in the abovementioned Quality Framework for the Accreditation Function, accreditation authorities are required to build stakeholder support and collaborate with other national, international and/or professional accreditation authorities. Stakeholders with an interest in the accreditation process include:

- **Governments:** who set the overarching strategic direction of the health care system, determine health regulation and contribute significantly to services and funding. In doing so, governments play a key role in setting workforce policy and practice.
- **Education regulators:** the quality assurance agencies for the higher education (TEQSA) and VET (ASQA or state-based authorities in Victoria and Western Australia) systems are responsible for regulating, monitoring and evaluating the performance of education providers. Education providers must meet the accreditation requirements of education regulators before they can seek accreditation under the National Scheme.
- **Health service regulators:** ACSQHC is the government agency responsible for developing the National Safety and Quality Health Service (NSQHS) Standards and oversees the accreditation of health service settings against these standards. The NSQHS Standards and accreditation processes intersect with National Scheme processes such as the accreditation of intern positions and specialist training posts/sites and the provision of quality clinical placements. In addition, the NSQHS Standards outline key health care practices that underpin the curricula of all health professions across the career continuum.
- **Education providers:** develop and deliver health programs of study designed to meet accreditation standards and attract students to their institution. Education providers consult and engage with a range of stakeholders including consumers and health professions to ensure that their programs of study continue to respond to the demands of the students, the needs of the health sector and the health care needs of the community.
- **Employers:** have a strong interest in the outcomes of education health programs. Employers require health graduates to have the knowledge, skills and professional attributes to deliver safe and high-quality health services. Many employers also provide clinical placements and/or vocational training to enable students/trainees to obtain practical experience and consolidate their academic learning.
- **Professional associations** represent, and advocate for, their profession. Professional associations can collaborate to inform and influence the development and implementation of accreditation standards and competency standards. By identifying (or opposing) opportunities for innovation and reform in professional education and/or practice, associations can influence the education and training of that profession.
- **Consumers:** as end-users of the health system, have a direct interest in influencing education and training to ensure the workforce remains responsive to the evolving health care needs of the community. Consumers provide a useful lens for assessing whether accredited programs are culturally appropriate and are responsive to population and demographic changes and to broader health and social care issues.

These stakeholders currently have varying roles in the conduct of accreditation functions and in influencing the operation of the accreditation system. Their roles are explored throughout the Report.

## 3 Funding and cost-effectiveness



This chapter assesses the current system for funding accreditation. It examines the reported income and expenditure of accreditation authorities and highlights inconsistent approaches in the collection of financial information. The chapter proposes improvements to financial and performance reporting in the National Scheme. It seeks to assess the cost-effectiveness of accreditation functions and concludes that funding principles are required to guide accreditation authorities to set fees and charges and improve the financial transparency and accountability of the accreditation system.

### Key messages

The National Law high-level guiding principles for efficiency, transparency and accountability have not been translated into specific business rules or frameworks to guide accreditation authorities in the setting of fees and charges.

Each accreditation authority has a different charging regime and different fees for accreditation functions and for the assessment of overseas trained health practitioners.

The fees and charges do not reflect the full cost of accrediting education and training as they do not include the internal costs incurred by the education providers or charges for examinations, supervised practice or specialist training.

The lack of a consistent accounting and reporting framework makes it difficult to conduct a valid comparison of cost-effectiveness across the different professions within the National Scheme, and with other sectors (outside of health) and other (international) jurisdictions.

The development of funding principles, which include guidance on cost recovery and the use of a consistent accounting methodology, is required to assess the cost-effectiveness of the accreditation system and improve its transparency and accountability.

### NRAS Review findings and costing analysis

The 2014 [NRAS Review](#) Final Report concluded that the Australian system was relatively expensive and there was evidence of rising costs and increases in the fees charged to providers. It noted the variability amongst accreditation authorities, including different fee structures, fee-setting methods and extensive duplication of processes.

As part of its work, the NRAS Review contracted the Professional Standards Authority (PSA), an independent body accountable to the United Kingdom (UK) Parliament, working in collaboration with the Centre for Health Service Economics and Organisation, to review the cost effectiveness and efficiency of the National Scheme. The PSA report, provided as an appendix to the NRAS Review final report, suggested that having 11 separate accreditation councils was likely to *“be an inherently more expensive arrangement for the delivery of this function”* (Appendix 3, p24). In addition, it expressed concern that, due to the accreditation authorities having a monopoly on the accreditation process, the continued lack of scrutiny could diminish any incentive to improve efficiency and cost-effectiveness.

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 1).

The analysis undertaken by PSA was challenged by accreditation authorities and National Boards on the basis that the differences in the scope, size and history of health regulation made any comparisons invalid. The PSA itself acknowledged that firm conclusions could not be drawn as to the cost effectiveness of the National Scheme based solely on its analysis. It stated “...*a much more detailed analysis of the differences of performance, process and approach within and between them would be required*”. (Appendix 3, p26).

Accreditation authorities expressed dismay that the NRAS Review findings were included in the deliberations of this Review. The Australian Nursing & Midwifery Accreditation Council (ANMAC) in its response to the Draft Report advised:

*“ANMAC objects to the repetition, without supporting evidence, of the UK Professional Standards Authority (PSA) assertion in the text of the Report...The Review misses the opportunity to clear this matter up, claiming lack of comparable figures, when the real problem is the egregious and simply traceable accounting errors in the PSA paper”.* (DR p2)

The PSA findings were a significant factor in the COAG Health Council requesting further investigation into the cost of accreditation functions within the National Scheme. Their findings highlight the difficulties in undertaking financial comparisons across (and within) existing accreditation systems without access to costing methodology, unit cost pricing and consistent financial data. These issues are explored in further detail later in this chapter.

## How does the National Scheme compare internationally?

In preparation for this Review, the Accreditation Liaison Group (ALG) compared the Australian accreditation arrangements with those of the USA, Canada, New Zealand, UK and Ireland. These countries were chosen due to similarities in the health services provided and to comparable standards of education for the health professions. The ALG concluded that there were key differences, such as:

- legislative frameworks and objectives, noting that only the Australian legislation had an explicit focus on workforce development, innovation and reform
- the Australian accreditation functions include the assessment of overseas trained health practitioners and overseas authorities, whereas other countries treat these as registration functions.

This Review assessed the comprehensive work of the ALG and undertook further investigation into some of the systems identified by the ALG.

### Box 3.1 International comparisons

The Comparison of International Accreditation Systems for Registered Health Professions Report ([‘International Comparisons Report’](#)) prepared by the ALG provides a comprehensive overview of the respective health accreditation systems in place across comparator nations. The ALG notes that New Zealand, UK and Ireland are most similar to Australia in that they have a co-regulatory system. Co-regulation is expressed as a system that has “*a strong partnership between industry and government; with the industry developing its own code of conduct or accreditation/ratings schemes with legislative backing from government*”. (p2)

Canada and the USA have different regulatory systems which operate at a state/provincial level. The USA is considered to be a ‘quasi regulated’ system where government influences business to comply and assists with the development of codes of conduct, accreditation and/or rating schemes, but does not play a role in enforcement. The Canadian system was seen as having aspects of both quasi-regulatory and co-regulatory systems.

Australia, Canada and the USA have federal systems of government. Australia has developed a national approach (leading to the establishment of the National Scheme), whereas USA and Canada have retained separate state/provincial approaches to regulation. As a result, there are variances in how health professions are regulated at the sub-national level. Canada and the USA have also developed a system of national examinations for registered professions (except for psychology and podiatry). The Review infers that the use of national examinations in these two countries is to allow for assessments of graduates against a consistent national benchmark, given the lack of a single national approach to accreditation.

### Box 3.1 International comparisons

While New Zealand has a single national Act governing the regulation of its health practitioners (the [Health Practitioners Competence Assurance Act 2003](#)), it has a ‘[scope of practice](#)’ approach to practitioner regulation while Australia’s National Scheme is based on a ‘[protection of title](#)’ model. A key difference with the ‘scope of practice’ approach is that it enables regulatory authorities to apply restrictions on the scope of practice of individual practitioners. In Australia, restrictions on individual scopes of practice are primarily undertaken through employer credentialing and privileging processes or following a complaint or notification. The varied use of ‘scope of practice’ (NZ and Canada) vs ‘protection of title’ (Australia, Ireland, UK and USA) suggests that this is influenced by local health systems and the broader regulatory context.

The [United States Department of Education and Training](#) (USDET) has a role in accrediting the accrediting authorities, so that each accredited authority has to meet consistent standards set by the USDET. The UK also has a national oversight process for health regulation, which is provided by the [Professional Standards Authority](#) (PSA).

The different legislative frameworks, nature and scope of health practitioner registration schemes, accreditation arrangements, governance arrangements, intersections with education portfolios, and funding and accounting methodologies make cost comparisons between Australian and international accreditation systems problematic. The Australian Dental Council (ADC) in its submission to the Discussion Paper advised:

*“Comparative analysis of fees across Councils doesn’t really reflect the real cost and relative quality of the wide diversity of accreditation and examination activities currently undertaken by each accreditation authority. This data is needed to appropriately define key principles for fee setting and levies. In the absence of this data, the ADC believes funding should continue to be set in accordance with the guiding principles of the Scheme through negotiation between the accreditation authority and the respective National Board; transparent, accountable, efficient and linked to effectiveness”. (DP p24)*

The Australian Medical Council (AMC) undertook an internal analysis of the cost of medical accreditation in the UK and Australia. its submission to the Discussion Paper noted:

*“The AMC’s best estimate of UK medical accreditation costs comes from GMC expenditure on quality assurance of programs. Using these numbers, UK medical accreditation costs are around A\$42 per registrant. The corresponding number in Australia is around A\$26. We have checked with the GMC to ensure that, in the main, this is an ‘apples with apples’ comparison”. (DP p7)*

The Review considers that, regardless of the difficulties, benchmarking against other like systems remains a worthwhile goal. The examination of the National Scheme’s current funding structures, policies and principles and recommended range of improvements are aimed in part to provide better transparency and accountability and to enable more robust assessments of the relative cost-effectiveness of accreditation systems between registered professions in the National Scheme and with other similar systems in Australia and internationally.

## Current Review’s analysis

Health Ministers when establishing this Review requested that it assess the “cost effectiveness of the regime for delivering the accreditation functions” (Appendix 2). To provide data to support such an assessment, the ALG undertook a project to quantify the cost of accreditation in the National Scheme. The resulting Cost of Accreditation in the National Registration and Accreditation Scheme (‘the [Costing Paper](#)’) is a comparative analysis of the income and expenditure by accreditation authorities in the exercise of their functions.

This Review acknowledges the significant work undertaken in compiling data from across 14 separate accreditation authorities and commends the ALG for the comprehensive information and analysis. The information on the functions (and income and expenditure) of each accreditation authority, as contained in the Costing Paper provides a useful template for future annual publication of income and expenditure across the entities within the National Scheme.

In analysing the Costing Paper and the 2014 PSA report, the Review concluded there was little benefit in attempting to draw further conclusions regarding the comparative cost effectiveness at this point. The reasons are clear:

- The financial data in the Costing Paper cannot be directly compared with the analysis undertaken by PSA for the NRAS Review. The PSA costing figures were based on data from the establishment of the National Scheme and the 2013–14 financial year while the Costing Paper uses data from 2013–14 to 2015–16. The

PSA review sought to establish unit cost pricing for individual accreditation activities based on the number of activities undertaken. However, its methodology could not accommodate variances in complexity, governance and length of assessment processes as this data was not available in a consistent and comparable format across the registered health professions in Australia.

- Cross comparisons require the calculation of a unit price for an individual accreditation activity which can then be used to compare the cost of undertaking the activity across health professions, sectors or internationally. However, this requires a common accounting framework which is used by all accreditation authorities.
- Due to the differences in accreditation and accounting practices, along with economies of scale, drawing any conclusion on current comparable cost effectiveness, even between professions covered under the National Scheme, would likely divert consideration of the necessary system changes and be counterproductive to the expected outcomes from this Review. For example, the Costing Paper (Table 15, p33) includes the mean cost of accreditation to registrants and education providers. This analysis indicates that the cost to a registrant ranges from \$269 for Aboriginal and Torres Strait Islander Health Practice to \$9 for Nursing & Midwifery. Similarly, the mean cost for education providers ranges from \$31,730 for Physiotherapy to \$5,882 for Nursing and Midwifery. However, a lower mean cost for does not necessarily translate to a more cost-effective or efficient process as it can be easily explained by the difference in the number of registrants. The analysis in the Costing Paper has not been adjusted to take into account the variances in the number of registrants, providers and programs, nor does it factor in issues of complexity, governance and assessment processes as outlined above.

As a result, the Review concludes that until there are common funding principles and a consistent accounting and reporting framework across Australia's National Scheme, valid and robust comparisons of cost-effectiveness across the different professions within the National Scheme, and with other sectors (outside of health) within Australia are not possible. The Review has made recommendations which address this deficiency. The Review also urges AHPRA and the relevant bodies to maintain and update the data collection underpinning the Costing Paper until it can be replaced by financial and performance reporting regimes as proposed in this Report.

## Existing approach to funding accreditation

When the National Scheme was being established in 2008, First Ministers agreed in the [Intergovernmental Agreement](#) for a National Registration and Accreditation Scheme for the Health Professions: *"it is intended that in the longer term the scheme will be self-funding"* (Clause 12.3). The guiding principles specified in the National Law do not explicitly require self-funding, but they do state that the National Scheme is to operate in a *"transparent, accountable, efficient and fair way"* (s3(3a)) 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"* (s3(3b)).

The National Law, Part 9, s208 – 212 set specific requirements on how income will be raised and paid into AHPRA's Agency Fund and payments be made from that Fund to enable National Boards and AHPRA to undertake their functions. This includes the operation of a separate account for each National Board (s208) and a specific requirement that any payment made from a National Board account is to be undertaken 'in accordance with an approved budget, or otherwise approved by the National Board' (s210(3)). The establishment of a separate account and approval process for each National Board has been interpreted as disallowing all forms of cross –subsidisation (where one National Board's funds are used to offset expenses incurred by another National Board). Beyond those provisions, the National Law does not prescribe how fees and charges should be set or how the income (including any proceeds from investments) earned by the National Scheme is to be allocated amongst the National Boards, accreditation authorities and AHPRA. There is no cross-subsidisation between the 11 accreditation councils and three committees, nor is there a central pooling of funds for identified cross-professional accreditation projects.

Practitioners' registration fees account for around 94% of total income received by AHPRA's Agency Fund to operate the scheme (AHPRA 2015-16 Annual Report). The process through which fees relating to each profession are credited to the respective National Board account is undertaken through a [Health Professions Agreement](#) (HPA) negotiated between AHPRA and each National Board. The Agreement includes funding for the overall administration of the National Scheme and funding to accreditation authorities. Health Ministers receive advice from AHPRA on the registration fees charged by respective National Boards; however, this advice does not include information on the underlying costs of regulation (such as the quantum and proportion of registration fees allocated to accreditation authorities). Similarly, accreditation councils are not required to disclose their processes for setting accreditation fees and charges on education institutions.

## Income sources

Each accreditation authority is required to generate income to sustain its accreditation and assessment processes. That income is either from National Boards or from fees paid by education providers. Nine of the 14 accreditation authorities (Chiropractic, Dental, Medical, Occupational Therapy, Optometry, Osteopathy, Pharmacy, Physiotherapy and Podiatry) source additional income from the assessment of overseas trained health practitioners and offshore competent authorities. Accreditation authorities can also generate income from other sources outside the National Scheme, such as skilled migration assessments.

The AHPRA Annual Report notes that in 2015–16, the total income to the Agency Fund was \$170,929,000 (of which \$161,038,000 was received from registrant fees). The Health Professions Agreements state that AHPRA receives 78% of all total income received by National Boards to meet its expenses (\$135,909,484 in 2015–16). This indicates that although cross-subsidisation is not explicitly provided for in the National Law, there is significant central pooling of funds to support the funding of common projects and shared overheads in the National Scheme.

Over the past 3 years (2013-2016), AHPRA has allocated approximately 4-7% of total income to accreditation activities.

Table 3.1: Total AHPRA income and expenditure

	2013–14	2014–15	2015–16
	,000	,000	,000
Total income	\$167,859	\$170,463	\$170,929
Total expenditure	\$151,887	\$168,602	\$169,077
Accreditation funding	\$7,438	\$11,659	\$9,754
% of total income	4.4%	6.8%	5.7%

The Costing Paper (p25) confirms that funding contributions from the National Boards are a more significant source of income for accreditation authorities compared to income generated from education providers, increasing from 66% of combined (National Board/education provider) income in 2013–14 to 73% in 2015–16.

The Review undertook further analysis (Table 3.2) of the accreditation authority income data provided in the Costing Paper (1), National Board accreditation expenditure as reported in the 2015–16 AHPRA Annual Report (2) and National Board budget allocations for accreditation activities to accreditation authorities (3).

Table 3.2: Reported expenditure on accreditation 2015–16 across all public reporting sources

Accreditation authority – Council or Committee	ALG Costing Paper Income received from National Boards (1)	AHPRA Annual Report National Board exp (2)	HPAs budget allocation (3)
Aboriginal & Torres Strait Islander Health Practice	\$158,000	\$158,000	\$184,200
Chinese Medicine	\$218,000	\$218,000	\$187,300
Chiropractic	\$205,865	\$207,000	\$172,900
Dental	\$421,000	\$473,000	\$506,000
Medical	\$2,871,411	\$3,446,000*	\$4,349,700
Medical Radiation Practice	\$307,000	\$306,000	\$200,106
Nursing & Midwifery	\$3,378,903	\$2,619,000	\$2,619,000
Occupational Therapy	\$6,600	-	-
Optometry	\$297,000	\$297,000	\$297,000
Osteopathy	\$198,507	\$219,000	\$217,732
Pharmacy	\$530,000	\$530,000	\$530,000
Physiotherapy	\$365,251	\$365,000	\$254,300
Podiatry	\$174,623	\$162,000	\$153,200
Psychology	\$740,000	\$754,000	\$753,600
TOTAL	\$8,639,854	\$8,698,000	\$9,374,638

\* The AHPRA 2015–16 Annual Report also notes additional funding of \$942,763 for the purposes of prevocational accreditation.



As shown in Table 3.2 National Boards contributed to the full range of accreditation activities except for the Occupational Therapy Board, which did not provide funding to its accreditation authority in 2015–16. The Occupational Therapy Council (Australia and New Zealand [OTC]) in its submission to the Discussion Paper stated:

*“The OTC made the decision the education providers should pay the full cost of program accreditation, including general administration and operating costs of the OTC. The same principle was adopted in relation to the assessment of overseas-trained practitioners. The OTC does not receive any funding from the National Board for either type of accreditation and has found the removal of an annual request for funding in these areas has contributed to a simpler and more effective relationship with the National Board that is more focused on the real issues concerning accreditation”. (DP p7)*

With the exception of Optometry and Pharmacy, the income reported as being received by accreditation councils from their National Boards is different from the reported expenditure on accreditation incurred by National Boards, which is again different to the original budget in the HPAs.

The budget notes in all HPAs indicate that *“Accreditation expenses include the costs of funding provided to (accreditation entity) for accreditation functions and related projects (Note 4)”*. The reference to ‘related projects’ raises the possibility that some of this funding may go to AHPRA or another entity. The Review sought clarification of this from AHPRA, but the agency was unable to quantify this amount and advised in correspondence to the Review:

*“The note regarding the accreditation line budgets in the HPA refers to the budget for direct costs for accreditation activities relating to each National Board. This will predominantly be the funding for each accreditation authority, including committees of National Boards and external accreditation authorities. It may include other funding provisions for direct accreditation costs incurred by each Board”.*

The AHPRA correspondence confirms that National Boards may also incur their own direct accreditation costs, but again this has not been quantified.

As outlined above, Schedule 5.2 of the HPAs includes functions provided by AHPRA to National Boards to support their oversight of accreditation functions, committees (where applicable) and standards. The 2015-16 the HPAs include an allocation of \$135,909,284 noted as an ‘Indirect Expense’ for AHPRA for the administration of the National Scheme. While the accompanying budget notes indicate that the Indirect Expense item includes support provided by AHPRA for accreditation activities, the budget does not specify the quantum or proportion of the AHPRA Indirect Expense that is used for this activity. Information provided to the Review by AHPRA indicates that it is taking on a greater role in administering all functions (including accreditation):

*“Over time the initial resources applied to deliver the core regulatory functions have developed to provide greater capacity for accreditation policy advice along with accreditation operations for those 3 professions with internal committees utilising the services provided directly by AHPRA. As the accreditation policy functions have developed over time they are vested in a range of roles that intersect with accreditation functions including advice to National Boards and also the negotiation and management of accreditation service agreements with external authorities. Within a multi-professional regulatory model the direct cost of services provided to accreditation committees is isolated and directly attributed to the relevant professions, the resources for accreditation policy and advice are more dispersed and form part of the allocated cost pool. This much broader cost pool is attributed to across the National Boards in line with our allocated costing model”.*

The AHPRA correspondence refers to expenditure by AHPRA on accreditation policy as well as accreditation advice to National Boards, though this has not been quantified.

The Review is advised that the AHPRA Indirect Expenses distribution is based on a cost allocation methodology developed by Moore Stephens in 2013 (explored later in this chapter), but that methodology did not factor in any expenditure on AHPRA accreditation functions. The interest of this Review in highlighting Indirect Expenses is not to question the need for AHPRA to support functions and to enable resource allocation flexibility across the National Scheme, but to illustrate the difficulty in determining the full cost of accreditation within the National Scheme.



## Accreditation authority fees and charges

The ALG reports that accreditation authorities collected fees of \$4.1 million (2013–14), \$3.8 million (2014-15) and \$3.7 million (2015–16) from education providers. Tables 3.3 and 3.4 contain information on the fees and charges levied by the respective accreditation authorities for accreditation and assessment functions.

As shown in Tables 3.3. and 3.4, each accreditation authority has a different fee for accreditation functions and for the assessment of overseas trained health practitioners. With the exception of the Australasian Osteopathic Accreditation Council (AOAC), accreditation authorities which charge an annual fee do not charge additional fees for reviewing previously accredited programs of study. While most accreditation councils include one site visit within their fees, the Medical and Occupational Therapy Councils charge separately for site visits. The above fees and charges do not reflect the full set of charges for accrediting education and training as they do not include charges for national examinations, supervised practice/internship or specialist training programs. It also does not include the internal costs incurred by education providers.

The overall level of fees charged to education providers and the quantum of the contribution of registrant fees for the accreditation activity appear to be largely determined by the total estimated costs for each accreditation authority to undertake their program of work in a no change scenario, as opposed to a methodology that is based on efficient and effective accreditation processes which could be applied across professions. This issue is explored later in this chapter.

Table 3.3: Course accreditation fees and charges levied by accreditation authorities as at September 2017

Profession	Accreditation new program	Re-accreditation	Major program change	Annual Fee	Extra site visit
Aboriginal and Torres Strait Islander health practice	\$3,000	-	-	\$3,000	\$3,000
Chiropractic	-	-	-	-	-
Chinese medicine	\$12,000	-	-	\$4,000	\$6,000
Dental	\$44,000	-	-	\$19,800	-
Medical	\$10,000	\$7,500	-	-	-
Medical radiation practice	\$20,000	-	-	\$4,000	-
Nursing & Midwifery	\$38,100	-	-	-	\$5,150
Occupational therapy	\$6,300	-	-	\$8,300	\$6,300
Optometry	\$60,000	-	-	\$8,000	-
Osteopathy	\$15,000	\$10,000	\$5,000	\$2,000	-
Pharmacy	\$30,900	-	\$7,210	\$18,450	-
Physiotherapy	\$25,000	-	-	\$15,800	-
Podiatry	\$30,000	\$30,000	\$10,000	-	\$5,000
Psychology	\$5,841	\$6,076	-	-	\$5,841

### Notes:

Where a fee is not listed, the Review was unable to find any public information on its existence or rate.

The Australian Dental Council has different annual charges for oral health therapy (\$12,100), dental hygiene (\$8,250), specialist (\$5,500) and prosthetist (\$6,600) programs for new oral health therapy (\$33,000), dental hygiene (\$16,500), specialist (\$16,500) programs.

The Australian Medical Council requires a deposit of \$20,000 from education providers.

The Australian Nursing and Midwifery Accreditation Council charges are for programs over 12 months. Charges apply for programs of less than 6 months (\$10,600), between 6-12 months (\$23,700) and for dual degree programs (\$53,600).

The Osteopathy and Psychology Accreditation Councils also charge application fees for programs of study and providers.

The Australian Pharmacy Council charges different fees for overseas campuses.

The Australian Physiotherapy Council provides a discount of 30% for multiple programs delivered by the same education provider.

Table 3.4: Overseas trained practitioner assessment fees levied by accreditation authorities as at September 2017

Profession	Overseas Trained Practitioner assessments	Overseas Trained Practitioner appeals
Aboriginal and Torres Strait Islander health practice	-	-
Chiropractic	\$4,000	\$250
Chinese medicine	\$1,158	-
Dental	\$7,110	\$610
Medical	\$6,790	\$215
Medical radiation practice	\$345	-
Nursing & Midwifery	\$300	-
Occupational therapy	\$1,200	\$600
Optometry	\$7,030	\$660
Osteopathy	\$5,250	\$1,000
Pharmacy	\$1,190	\$450
Physiotherapy	\$7,125	\$550
Podiatry	\$670	\$300
Psychology	\$700	-

Notes:

Where a fee is not listed, the Review was unable to find any public information on its existence or rate.

The Australian Medical Council OTP assessment charge for doctors above includes establishment of a portfolio, multiple choice questionnaire and clinical exam charges.

The Australian Pharmacy Council OTP assessment fee does not include the cost of examination (\$3700).

The Optometry Council of Australia and New Zealand also charges an application fee of \$1,650 to OTPs.

The Australian Physiotherapy Council has a lesser fee for OTPs with qualifications on the "Equivalent University" list

The Costing Paper shows, over the period 2013–14 to 2015–16, the overall activity, income and expenditure of all accreditation councils. Fees charged to onshore education providers not only contributed to the cost of assessing domestic programs of study, but also supported the provision of advice to National Boards and the development of accreditation standards (Tables 3.5 and 3.6).

Table 3.5 Total accreditation authority income and expenditure

Total income and expenditure	2013–14	2014–15	2015–16
Total income	\$40,656,418	\$42,307,716	\$40,353,706
Total expenditure	\$37,757,262	\$36,592,250	\$35,366,351
Total annual surplus/(deficit)	\$2,799,157	\$5,715,467	\$4,987,355

Table 3.6 Total accreditation authority activity

Accreditation function	2013–14	2014–15	2015–16
Accreditation standards developed	85	9	4
Accreditation standards reviewed	7	6	4
New programs of study accredited	77	90	85
Programs re-accredited	95	140	97
Programs monitored	414	472	610
Site visits undertaken	104	169	91
Overseas authorities assessed	8	7	7
Overseas qualified health practitioners assessed	13,444	10,202	8,765

The analysis undertaken by the ALG does not include income and expenditure on functions that have been assigned to specialist colleges or postgraduate medical councils for the accreditation of medical intern or specialist training positions. The Royal Australasian College of Obstetricians and Gynaecologists submitted:

*“Funding is not provided by the Medical Board to the Specialist Medical Colleges for assessing and accrediting training posts. This is a cost borne by members of RANZCOG”. (DP p4)*

AHPRA advised the Review that funding from the Medical Board to postgraduate medical councils for the period 1 July 2014 to 31 December 2014 was based on individual funding arrangements established by the prior state and territory boards. It advised that from 1 January 2015, a new funding model was introduced that applied to all intern training accreditation authorities. However, no further detail was provided on the funding model.

Table 3.7 Total medical interns and National Board funding

2013–14		2014–15		2015–16	
Total interns	Funding	Total interns	Funding	Total interns	Funding
3,287	\$986,797.94	3,299	\$925,369.50	3,442	\$942,763.80
Rate per intern	\$250	Rate per intern	\$255	Rate per intern	\$249

### Income from other sources

The Costing Paper indicates that in 2015–16, approximately 66% of total accreditation authority income was from ‘other sources’, defined as “... income derived from sources other than National Boards and education providers, such as the assessment of overseas-qualified practitioner fees” (p23) (noting, however, this is skewed by substantial income received in this category for the AMC, ADC, Australian Pharmacy Council (APC) and Australian Physiotherapy Council (APhysioC) relative to their core accreditation income). The Pharmacy and Optometry Councils provided additional information to explain that income from ‘other sources’ includes revenue generated through examinations, intern accreditation, and accreditation of organisations providing continuing professional development (CPD) programs (in the case of Pharmacy) or as a result of the transition from discontinued courses to new courses (Optometry).

Based on an analysis of income and expenditure from ‘other sources’ in the Costing Paper, it is noted that from 2013–14 to 2015–16, with the exception of the Optometry Council (which incurred losses of \$359,256 over the three-year period), the remaining eight accreditation authorities that undertook assessments of overseas trained health practitioners made a surplus in the exercise of this function (Table 3.8).

Table 3.8 Overseas Trained Practitioner assessment surpluses 2013-14 to 2015-16

Chiropractic	\$46,422	Osteopathy	\$61,019
Dental	\$4,577,897	Pharmacy	\$739,694
Medical	\$8,669,312	Physiotherapy	\$1,292,745
Occupational therapy	\$208,400	Podiatry	\$188,515

The APC in its submission to the Draft Report clarified that whilst it may have made a surplus from activities such as assessing overseas trained practitioners, it has incurred overall deficits since 2014/15:

*“The APC has run at a deficit for the past three years... Any surpluses generated prior to that arose from our examination delivery business for a number of clients outside the National Scheme, and the APC reinvested much of this back into further developing the pharmacy profession through the APC Advanced Practice Credentialing Pilot undertaken in 2015 and 2016. The apparent \$739,664 “surplus” generated by APC in “other income” over the past three-year period does not take into account the overhead costs of investments APC has made in modern ICT infrastructure, and other overheads”. (DR p1)*

The advice from the APC confirms the perception that income generated from sources such as the assessment of overseas trained practitioners is used to subsidise other activities. The Health Professions Accreditation Collaborative Forum (HPACF) also noted in its submission to the Discussion Paper:

*“Cross-subsidisation is a persistent feature in many public and semi-public settings. For example, fee paying students in some courses in Australian universities cross-subsidise other educational and research activities. Accreditation cannot operate effectively unless it is fully funded, so changes in this area would require agreement and understanding on the part of registrants or education providers who are the other main sources of accreditation income”. (DP p10)*

Whilst using revenue generated from commercial activities to support public interest functions is not unreasonable, the Review does not consider the assessment of qualifications of persons seeking to migrate and work in Australia as a purely commercial function. It also limits transparency; is counter to a user pays methodology; and can be a source of financial instability. In terms of the latter, whilst funding from National Boards and onshore education providers is a reasonably stable source of income for accreditation authorities, income from the assessment of overseas trained health practitioners can vary and depends, in part, on whether the profession remains a priority occupation for the purposes of skilled migration. The Commonwealth Department of Health's submission to the Discussion Paper also drew attention to this variability when it noted:

*"It is in the interest of all stakeholders to ensure organisations are not vulnerable should there be a significant change in demand for certain functions, including in the assessment of overseas professionals".* (DP p4)

The Australian Dental Association in its response to the Discussion Paper similarly cautioned against an overreliance on other income sources in its submission:

*"Policy decisions beyond the control of the accrediting body could significantly impact this income stream. If onshore programmes become partially dependant on these income streams, their ability to continue to function effectively could be threatened if government policy decisions lead to reduced income".* (DP p7)

NSW Health also argued against cross-subsidisation and overcharging overseas qualified practitioners in its submission on the Discussion Paper:

*"The fees that are set for assessment of overseas qualified practitioners should be determined by the cost of undertaking these assessments by the education providers and not used to cross subsidise accreditation functions for on-shore programs. ... Charging a fee that is more than the cost of assessment may be perceived as unethical, particularly as there is no guarantee of employment after assessment of the qualifications. Fees should not be set to discourage applicants from applying for assessment of their qualifications but to cover the costs of the assessment process".* (DP p3)

## Education provider costs of accreditation, other than fees

While education providers are charged fees for processes undertaken by accreditation authorities, they also incur additional internal costs as part of their preparatory work. As noted by Universities Australia in its submission to the Discussion Paper:

*"There are administrative cost pressures on both universities and accrediting bodies and administration is seen to be a large part of the cost ... The costs of external accreditation exceed the fees paid to the external accreditation body. Staff are employed within universities to support the preparation of the documentation and to support academic staff in developing the curricula".* (DP p5)

Universities Australia also provided an example of a university that employed three full-time staff to provide administrative and curriculum support for internal and external accreditation processes and advised that:

*"... course accreditation costs the same irrespective of the number of students who take up the course ... there are double accreditation costs for double degrees even where this seems inappropriate ... sometimes two separate course accreditation fees are charged for two courses in the same discipline (for example an undergraduate and postgraduate entry level course) even when accreditation of both courses has occurred during the same site visit".* (DP p6)

Data provided by universities to the Review indicate that internal costs for accreditation of a single course can range from \$70,000 to in excess of \$200,000 per course per annum. This includes staff time preparing documentation and organising assessment site visits. The University of Queensland noted in its submission to the Discussion Paper:

*"The current model of highly centralized accreditation systems is expensive. The focus is on monitoring compliance with a complex and arbitrary set of rules and the burden of reporting against those rules is costly. Example: the fee for the accreditation visit by APAC to a Go8 School of Psychology in 2016 was over \$100,000. The indirect costs for staff involved in preparing the application and responding to requests for additional information was over \$70,000".* (DP p2)

## How are accreditation fees determined?

In terms of the National Scheme budget process, in correspondence to the Review, AHPRA advised that:

*“AHPRA and the National Boards follow a hybrid model for budgeting their income and expenses along with the resultant equity position every year. The budgeting process is based on reviewing their historical spend and expected spend by each line and category for the budgeting period. The costs are then allocated to the various lines in their budget Income and Expense statement. This is agreed on an annual basis between Boards and AHPRA within the multi-year Health Profession Agreement Framework in line with five year forward projections being considered to support fee setting and expenditure strategies”.*

National Boards provide funding to AHPRA for administration functions based on a cost allocation methodology. The methodology was reviewed by [Moore Stephens](#) in 2013 based on a three-month timesheet data capture exercise across sections of the AHPRA workforce by profession. It did not include, however, any accreditation functions. At the time, Moore Stephens indicated that:

*“We presented AHPRA with an alternate methodology to the one in use since inception, at the time, however we also indicated that due to the infancy of the National Scheme, there were weaknesses in the quality and quantity of AHPRA’s costing data that limited the effectiveness of the adoption of a best practice methodology until such data were accumulated and tested over time. The impact of the addition of 4 new professions from 1 July 2012 also added to the complexity of establishing an appropriate cost model”. (DP p2)*

Moore Stephens further recommended that:

*“... management continue to accumulate data that were reliable and meaningful, enabling AHPRA to implement a cost allocation methodology that would withstand both internal and external scrutiny”. (p2)*

AHPRA advised the Review that it has recently commissioned Deloitte Access Economics to undertake an update of the Moore Stephens’s cost allocation methodology. The Review has not been provided with the Terms of Reference for this work; however, in correspondence to the Review AHPRA advised:

*“The outcomes of the Activity-Based Costing project are not expected to change the budgeting methodology. The work is being undertaken to understand the current costs incurred by AHPRA to perform all the regulatory functions including accreditation. The analysis of AHPRA’s cost base will be done based on the various activities performed by function and profession and also at a jurisdiction level and then nationally”.*

## Accreditation authority budget processes

The process for determining the funding amount required from National Boards is via an annual request based on the work plan of the accreditation authority. Information provided by AHPRA directly to the Review indicates that National Boards have different approaches. Some National Boards allocate an amount per registrant, while others base their funding on historical contribution levels. AHPRA further advise that the details are set out in formal agreements:

*“The terms of the agreement are generally consistent across the professions and reflect the accreditation functions in the National Law. The profession specific elements are set out in a Schedule. The agreement provides for an annual update of Items 1 and 4 of the Schedule, which contain the profession specific workplan and funding detail”.*

While accreditation costs should be a factor in determining annual registrant fees, the Review has not been provided with information as to how that occurs or its relationship to the accreditation authorities’ annual budget submissions. In addition, the joint National Boards/AHPRA submission to the Discussion Paper advised that the Consumer Price Index (CPI) provides guidance in setting of annual registration fees:

*“We have an agreed policy that any requirement to increase the cost of registration fees above the forecast CPI band in a year requires advice to Ministers in the form of a business case. There is currently a similar position taken by AHPRA to our service agreements with Councils for accreditation fees in that proposed increases above the CPI band require agreement from the Board and AHPRA”. (DP p6)*

While a CPI heuristic is widely used in budgeting processes, it has three major limitations. It assumes:

- the original base levels of accreditation fees were set on robust cost recovery principles and they represented the cost of services which were efficiently and effectively delivered

- cost components (wages, other operating costs, capital charges) all move in line with CPI
- that no further productivity gains have been achieved in delivering the accreditation functions.

The Australian Psychology Accreditation Council (APAC) pointed out some of these deficiencies in its response to the Discussion Paper:

*“We note that AHPRA’s response to the Snowball Review’s concern about pricing was to add a new term to our most recent Annual Funding Agreement, that fees charged to providers could not increase by more than CPI. Setting aside the implications of the Agreement making requirements relating to Councils’ commercial arrangements with third parties, this edict unfairly disadvantaged those Councils, like APAC, whose fees have historically been quite low. The fees we currently charge providers do not cover the direct costs of site visits and administrative costs, and we are currently using reserves to cover the considerable cost of developing new standards”. (DP p15)*

In terms of the methodology used by accreditation authorities to calculate the fees and charges levied on education providers and others, the ALG noted in its Costing Paper that:

*“Other than the objectives and guiding principles of the National Law, there are not as yet more specific agreed funding principles for accreditation. National Boards have commenced working on funding principles and will consult on these in the next few months”. (p38)*

The HPACF also noted the intention to develop funding principles in its submission to the Discussion Paper:

*“Because accreditation lies at the boundary of regulation and service, accreditation authorities do not attempt to fully recover accreditation costs from education providers ... A degree of pricing flexibility is desirable, given the different configurations and scales of accredited professions..... Recently discussions have begun between AHPRA, the National Boards and the Forum on the funding principles for accreditation functions across the professions. The Forum is keen to progress this work”. (DP p9)*

The HPACF reiterated this commitment in its submission to the Draft Report:

*“The Forum agrees that funding of accreditation should be fair, transparent and sufficient for the tasks, and supports the development of funding principles to guide boards, education providers and accreditation authorities in this regard”. (DR p3)*

These matters are addressed in greater detail later in this chapter.

## The financial standing of accreditation authorities

The Costing Paper indicates that five accreditation councils made operating losses in the 2015–16 financial year (Nursing and Midwifery, Occupational Therapy, Optometry, Pharmacy, and Psychology) and six accrued surpluses ranging from \$14,000 to \$4.86 million (Chiropractic, Dental, Medical, Osteopathy, Podiatry, and Physiotherapy). The three committees had exact alignment of income and expenditure. Information provided by AHPRA to the Review confirms that for the three committees, the National Boards cover the difference between income received from education providers for the assessment of programs of study and the expenses incurred, thus resulting in a zero balance at the end of the financial year.

The Costing Paper indicates that the management of accreditation seems to be often based on cross-subsidisation within the functions of a council, where surpluses made from one activity fund other activities. The Costing Paper indicates that the Council on Chiropractic Education Australia used income from ‘other sources’ for the development of accreditation standards and assessment of programs of study and education providers. The Australian and New Zealand Podiatry Accreditation Council used funding from ‘other sources’ for its accreditation of programs of study and education providers. In some cases, the deficits are being offset by income received from functions undertaken outside the National Scheme. The ANMAC 2015–16 Annual Report (p57) indicates that the deficits incurred from accreditation functions were offset by activities such as skilled migration assessments.

The figures indicate varying levels of surpluses and deficits across respective activities. Caution should be exercised, however, in reaching any particular conclusion, as many councils advised that they do not normally record expenditure in the manner presented in the Costing Paper. As noted earlier, there is currently no common methodology or framework used by accreditation authorities for the sharing of costs between registrant fees, charges to education providers and fees charged to overseas trained health practitioners or overseas competent authorities.



The Costing Paper concludes that:

*“A large majority of Accreditation Authorities reported net results that showed a break even, or in many cases, a deficit result [with the exception of the Australian Medical Council and Australian Dental Council]”.*  
(p22)

Due to the disparity in financial data from the various sources and the lack of accrual information on the use of unexpended funds, the level of outstanding liabilities and how cash losses were managed in any given year, the Review is reluctant to conclude whether operating expenses exceed or fall short of income received on any consistent basis.

The processes for 12-monthly budgets negotiated between accreditation councils and National Boards appear to be treated as standalone negotiations and do not contain information on the outcome of previous budgets, or the costing methodology used. The budgets are silent on how previous surpluses and deficits should be treated and each accreditation authority is largely left to its own devices to deal with them.

Accreditation authorities are protected from personal liability under the National Law for accreditation and assessment functions (s236(c) and (d)); and (Schedule 7, Part 3(12)). However, an analysis of publicly available annual and directors’ reports show that all councils have accrued equity. While accruing and investing income received for performing National Scheme functions over a number of years can be considered an appropriate strategy to smooth annual variability in income and expenditure, there does not appear to be a consistent approach to determining the size of equity or the use of such equity as part of annual funding agreements. Given the equity accrued by accreditation authorities largely arises from the performance of the functions under the National Law, the Review considers that the purpose for its accrual and use should be transparent. This is considered further in Chapter 7.

## Who should fund accreditation?

As previously noted, when the National Scheme was being established in 2008, First Ministers agreed *“it is intended that in the longer term the scheme will be self-funding”* (Clause 12.3). The Review, therefore, explored how costs could be allocated across the beneficiaries of the system. If a user (beneficiary) pays principle was to be followed, there are three broad groups of accreditation system beneficiaries:

1. For **education providers**, the system provides a quality assurance process that enables them to attract students to programs of study and generate income. For Commonwealth Supported Places (CSPs), programs of study are classified according to [Commonwealth funding clusters and student contribution bands](#), thus fixing the maximum income an education provider can receive per student. A university’s ability to generate higher levels of net income from the delivery of programs of study to these students is largely dependent on the number of students enrolled in CSPs and associated economies of scale.
2. The ability for a university to boost its income is also influenced by its capacity to attract international students, where the fees set could include course overheads such as accreditation. The numbers of international students are highly dependent on quality of the courses and the reputation of the providers, as well as the opportunity for those students to be subsequently registered and either pursue employment opportunities in Australia or have those qualifications recognised in other jurisdictions.
3. For **students**, the benefit they accrue is in being able to undertake accredited programs of study that can lead to employment. Graduates, in most circumstances, become registered practitioners and obtain benefit through the protection of the reputation of the profession.
4. **Health consumers** gain benefit through receiving health services from well-educated and trained health practitioners and through a system of regulation that monitors health practitioners and can act as appropriate to ensure the safety and quality of their practices.

Education providers and registrants directly contribute to the funding of accreditation. Consumers (and the general taxpayer) do not. Some submissions advanced the premise that the use of registration fees to fund accreditation means that the professions should determine how that money should be used. This view tends to be reinforced by the National Scheme structure where the registration fees for each profession are credited to the respective National Board account and distribution is determined by each Board.

The Review considers that simply identifying the direct contributors does not truly reflect the ultimate source of funding. Registration fees paid by registered practitioners comes from income primarily derived from salaried employment, MBS payments, private health insurance remuneration, and from fees they charge to consumers

([OECD data](#) suggests over 20%) through out-of-pocket expenses and insurance premiums). Given this, the Review concludes that the accreditation system should continue to be directly funded through fees charged to education providers and registrants, though issues of relative proportion remain.

## A new approach to funding accreditation

Section 210 of the National Law guides when and for which purposes payments can be made from a consolidated fund administered by AHPRA referred to as the Agency Fund. Section 210(3) states that payments “*may be made from a National Board’s account kept within the Agency Fund only if the payment is in accordance with the Board’s budget or otherwise approved by the Board*”. As noted earlier, AHPRA is required to maintain separate National Board accounts and, as stated in s210(3), individual National Boards must approve the quantum of their registrant fees that are to be used for accreditation or other purposes.

The current funding process is administratively cumbersome. While the National Scheme is a single scheme administered by a single national agency, the financial rules are not consolidated and remain based on separate annual negotiations with 14 National Boards. Some improvement can be expected with multiyear HPAs commencing from 2017, thus providing greater financial certainty and streamlined administrative processes. It should be possible to extend this approach to accreditation functions, given that they follow periodic assessment cycles that are planned in advance. This provides a stable work program where deviation would be primarily a result of a policy change or new projects, which would need to be negotiated with National Boards. The ALG, in its Costing Paper, argues for a stable funding model for accreditation authorities:

*“Proper governance of Accreditation Authorities requires that funding sources and expenditure be managed so as to provide appropriate reserves for future infrastructure and development, and security against funding shortfalls due to one-off and/or unforeseen circumstances. It is also necessary for the Accreditation Authorities to cost the quality improvement of their processes as a margin on fees”.* (p22)

Accreditation councils that charge an annual fee benefit from a recurrent funding stream and are able to spread the cost of accreditation over the cycle. However, others are vulnerable to the volatility of periodic accreditation cycles, which can result in significant activity and income in one year and little in the following. Annual fee frameworks provide a stable source of income to an accreditation authority and enable education providers to amortise expenses over the life of the accreditation cycle.

A uniqueness of the National Scheme is that it is bound by eight sets of state and territory legislation. While most jurisdictions adopted the legislation enacted by the Parliament of Queensland, each respective version of the National Law reigns supreme in each jurisdiction. The Commonwealth, states and territories have guidance documents to direct statutory authorities and government entities in setting fees and charges. This guidance largely aligns fees and charges with cost recovery principles while enabling ‘over recovery’ (surpluses) to cover overheads or to manage financial variability in income and expenditure.

Beyond the National Law, other state or territory legislation or guidance documents do not apply (or have been specifically disapplied) to the National Scheme. The intention of the National Law was thus to incorporate direction on the financial management of the National Scheme within it. However, whilst the National Law specifies how fees will be held, it does not offer any guidance on how fees should be set or any requirements for financial transparency (beyond an annual audit of AHPRA financial statements). The HPACF in its response to the Draft Report noted:

*“... a complete picture of NRAS accreditation costs would be facilitated if registration boards and AHPRA could add their accounting of accreditation related activities to those already provided by the ALG”.* (DR p4)

While the AManC has established a Finance, Audit and Risk Management Committee (FARMC), its [Terms of Reference](#) focus on financial strategy, risk management and audit for AHPRA and National Boards only. The FARMC Investment Policy and its Internal Audit Terms of Reference do not contain information on whether it has any oversight over accreditation funding.

## The Commonwealth’s charging framework

The Review considered instruments and policies available to Commonwealth, state and territory entities to set fees and charges and considers that the most relevant policy framework for this national role is the [Australian Government Charging Framework](#) (‘the Framework’, Box 3.2). The Framework states that “*the cost recovery policy promotes consistent, transparent and accountable charging for government activities and supports the proper use of public resources*”. (p5) It is designed to enable a common and consistent approach to planning, implementing and reviewing government charging. Its underpinning principles provide a sound foundation.



## Box 3.2 Australian Government Charging Framework

**Transparency** –making available key information about the activity, such as the authority to charge, charging rates, and, where relevant, the basis of the charges.

**Efficiency** –delivering activities at least cost, while achieving the policy objectives and meeting the legislative requirements.

**Performance** – which relates to effectiveness, risk mitigation, sustainability and responsiveness. Engagement with stakeholders is a key element of managing and achieving performance. Entities must regularly review and evaluate charges in consultation with stakeholders to assess their impact and whether they are contributing to government outcomes.

**Equity** – where specific demand for an activity is created by identifiable individuals or groups, who should then be charged for it, unless the government has decided to fund that activity on grounds of broader public interest. Equity is also achieved through the government’s social safety net, to ensure that vulnerable citizens are not further disadvantaged through the imposition of a charge.

**Simplicity** – whereby charges should be straightforward, practical, easy to understand and easy to collect.

**Policy consistency** – charges must be consistent with government priorities and policies, including entity purpose and outcomes. Government agreement may be required for the introduction of new charges and/or changes to charges.

Source: Australian Government Charging Framework - Resource Management Guide No. 302 (p 9)

The Framework includes additional guidance through the [Australian Government Cost Recovery Guidelines](#) which are based on cost recovery principles and include a requirement for efficiency and effectiveness. The cost recovery process includes the development of a [Cost Recovery Implementation Statement](#) (CRIS). The CRIS is similar to Regulatory Impact Statement (RIS) requirements, and is designed to ensure best practice in the setting of fees and charges by entities that have a monopoly function assigned through legislation. The CRIS involves the development of a policy case, policy proposals and stakeholder consultation. Education regulators are already required to comply with the Cost Recovery Guidelines when setting fees and charges. CRISs for the [Tertiary Education Quality Standards Agency](#) and the [Australian Skills Quality Authority](#) are publicly available on their websites.

Accreditation authorities have expressed concern that the detailed focus on processes in the Commonwealth Charging Framework is disproportionate for accreditation functions. The HPACF in its submission to the Draft Report advised:

*“...the Forum expresses reservations regarding the recommendation which relates to the proposed use of Cost Recovery Implementation Statements (CRIS)... Whereas in the case of the Commonwealth government these processes often relate to income streams in the order of millions of dollars per annum, in the case of accreditation they would be applied to organisations with annual cost recovery amounts as low as \$20K to \$30K. The Forum considers that mandating the use of these regulations from another sector with different operating requirements would be pose an unreasonable burden... The Forum considers that the development of funding principles described above should include the development of fit-for-purpose cost recovery implementation processes which are consistent with the scale of the accreditation authority and with legislation governing the not-for-profit sector”. (DR p3)*

Similarly, specialist colleges noted that the requirement of a CRIS could be considered excessive if it also applied to instances where fees were not charged for the accreditation function. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists in its submission to the Draft Report highlighted:

*“Public funds are not used for training site accreditation by RANZCOG, and therefore do not apply to this activity...Fees are not charged to public/government funded institutions - instead costs are recovered only from private businesses ···It would be possible to adopt a cost recovery model; however, where fees are not currently charged, this would need to be reviewed and passed on. This would lead to those training sites (hospitals) incurring costs where presently they do not... This is not acceptable to the RANZCOG Board as it could mean higher costs are passed on to Fellows and members, and to those who receive the benefit of the RANZCOG accreditation processes i.e. hospitals and the public. If all medical specialist colleges charged sites for accreditation on full cost recovery principles, then costs in public health would inevitably rise to accommodate the increased expenses”. (DR p2)*

The Review agrees that the development of a charging framework and CRIS should be proportionate to the size and complexity of the activity being undertaken. The Review therefore proposes that a CRIS template, underpinned by agreed funding principles, be developed specifically for the National Scheme. In addition, the requirement of a CRIS should only apply to cases where fees and charges are levied for accreditation and assessment functions undertaken under the National Law.

## Funding principles

Accreditation authorities have been granted monopoly functions covered under statute by National Boards. The Review considers that accreditation authorities should therefore be required to align business and accounting practices for the performance of those functions to what is expected from other public entities. While most accreditation authorities are established as private companies, the performance of their accreditation functions should be subject to the level of transparency and accountability expected from any public entity. The Queensland Government [Performance Management Framework](#) policy describes this as the:

*“... public defensibility test where activities and decisions are open to reasonable scrutiny and can withstand a public defensibility test in the context of fairness, equity and value for money”. (p4)*

As part of the first round of consultations on the Discussion Paper, the Review sought stakeholder views on the principles for setting fees and charges for accreditation functions, including how the respective shares of income provided from registrants and education providers should be determined. The Review received limited responses, with none suggesting how respective shares might be calculated. Where stakeholders did express a view, they noted the lack of consistent funding principles.

Universities Australia, in its submission to the Discussion Paper, called for more transparent principles in setting out what costs cover:

*“Many universities recognise that accreditation staff work solidly when undertaking the accreditation process however more transparency in what costs cover would be welcomed. While UA members also recognise that accreditation councils need to run as businesses, they are not-for-profit, and prices should reflect this”. (DP p5)*

Curtin University advised:

*“Key principles related to funding that should apply across the NRAS scheme are transparency and consistency in how accreditation costs are derived. Curtin supports the articulation of a consistent, clear, publicly stated philosophy or set of principles that relate to funding of activities of accreditation authorities. Remuneration of Accreditors should be standardised across all professions”. (DP p3)*

This was supported by the Flinders University Faculty of Nursing, Medicine and Health Science, which stated:

*“Key principles for consideration include consistency and equity across health professional programs, and accreditation services should be not-for-profit and cost neutral. The Faculty supports a transparent, fair, and reasonable approach to fee setting for this service. Given their role as a public good, all accreditation services, be they for education programs or overseas qualifications, should be not-for-profit and cost neutral”. (DP p2)*

TAFE NSW suggested that fees and charges should reflect the “level of risk of the provider based on evidence of compliance with standards” (DP p2). It further noted that, as funding received for training by the Government was designed to support the delivery of education programs, it did not fully cover the costs associated with accreditation and monitoring, and as a result these costs can be transferred to students as increased fees.

The Review sought stakeholder feedback on the proposed development of funding principles in its Draft Report. The response to was largely positive, as is evident from the following sample of responses.

### Box 3.3 Stakeholder responses to the development of funding principles

#### Swinburne University of Technology

*Swinburne University of Technology supports the development of funding principles in order to guide accreditation authorities in setting fees. We further concur with the ... recommendation that a Commonwealth Cost Recovery Implementation Statement should be mandated when fees are set by said authorities. (DR p1)*

## Box 3.3 Stakeholder responses to the development of funding principles

**Royal Australian College of General Practitioners**

*The RACGP supports consistent transparency and accountability of accreditation funding to improve efficiency. The RACGP notes that past accreditations have been costly, and there is a need to improve cost-effectiveness (DR p1)*

**Council of Deans of Nursing and Midwifery (Australia & New Zealand)**

*Council supports greater transparency and equity across the professions in the setting of fees and allocation of funding from the National Boards for accreditation processes. Council believes in the interests of equity and consistency that principles for a single national fee are set, once general consultation with stakeholders has been implemented. Efforts to improve greater accountability are also supported. (DR p1)*

**South Australian Department of Health and Ageing**

*The Department notes the complexities pointed to in the Review in relation to assessment of cost effectiveness of the accreditation system and welcomes efforts to increase transparency, consistency and accountability. (DR p1)*

**Australian Medical Council**

*The AMC considers that the key principle should be that funding of accreditation functions is fair and transparent and sufficient to ensure that the objectives of the National Law can be achieved. This should be balanced with accountability – not just of accreditation authorities - but also of AHPRA and National Boards. (DR p1)*

**Australian Pharmacy Council**

*The APC supports transparency of costs and fees within the scheme and would welcome the development of guiding funding principles to inform boards, education providers and accreditation authorities in this regard. The APC concurs with the Review that the current system is not equitable for the various professions; it is based on historical practice preceding the commencement of the National Scheme. This is a fundamental structural issue that needs to be addressed for the future. (DR p1)*

**Optometry Australia**

*In principle, there appears to be merit in developing funding principles to guide accreditation authorities in setting fees and charges, provided that such principles are sufficiently flexible to be fairly applied to accrediting organisations required to accredit a large number of courses, and those required to accredit a relatively small number of courses. (DR p1)*

The National Law has set high-level guiding principles with regards to efficiency, transparency and accountability. However, these have not been translated into specific business rules or frameworks to guide National Boards or accreditation authorities in the setting of fees and charges or into consistent reporting templates across the various National Scheme publications. The Review proposes the development of funding principles to guide the setting of fees and charges paid by education providers as well as National Board allocations of registrant fees for accreditation. This methodology should seek to identify the funding pool for accreditation, including surpluses generated, deficits incurred and the use of investment or equity income by accreditation authorities.

The proposed funding principles should also be considered for applications across the broader National Scheme to enable the fair and transparent assignment of costs across all its functions. The ADA also noted the importance of funding principles for the National Scheme in its response to the Draft Report:

*“The outlined funding principles should apply equally to all National Boards and accreditation authorities, including determination of funding to accreditation authorities through registrant fees and how cross-profession projects identified can be funded”. (DR p8)*

The joint National Boards/AHPRA in their submission to the Discussion Paper indicated their support:

*“A starting point would be to consider the application of established funding principles from other sectors, modified as relevant to the National Scheme and accreditation context. This may provide more guidance about how the respective share of income provided from registrants and education providers should be determined”. (DP p6)*

They reiterated their support in their submission to the Draft Report:

*“We support recommendations 1 and 3 which are consistent with the National Boards/AHPRA joint submission to the ASR Discussion Paper (our previous joint submission). As noted in our previous joint submission, funding principles should draw on examples of good practice from other sectors such as Cost Recovery Implementation Statements (CRIS). There may be others”.* (DR p4)

The Review acknowledges the views of stakeholders, and notes that:

- the national accreditation fee structures of TEQSA (as a point of comparison) are under review
- acceptance and implementation of some of the recommendations in this Review should result in a reduction in overall costs by reducing the high levels of duplication
- critical to the development of funding principles will be increased transparency in setting of fees and charges and reporting of financial information.

The Review concludes that funding principles should be developed that:

- are founded on transparency, accountability, efficiency and effectiveness
- establish the full cost of accreditation functions (including the development of standards, policy advice, cross-professional accreditation activities, accreditation and assessment functions)
- provides guidance on prudent limits on over-recovery (surpluses) and under-recovery (deficits) including the use of equity and other investment income
- establishes an annual fee structure to cover the cost of ongoing monitoring and reporting and seek to amortise expenses over the life of the accreditation cycle
- include a cost recovery policy and a cost allocation methodology to guide the allocation of costs between education providers and registrants (through National Boards)
- establish a consistent (accrual) accounting methodology and business principles to enable comparison across professions
- require the development of a proportionately scaled CRIS when setting or reviewing fees and charges for accreditation activities.

The funding principles should be subject to wide stakeholder consultation, be approved by the Ministerial Council and form the basis of all funding agreements.

## Accountability and transparency

The National Law has established reporting requirements (including financial reporting) (Schedule 3, Part 3). Entities operating within the National Law are only required to comply with the reporting requirements stated in the National Law. This distinguishes the National Scheme entities from most other statutory entities, as they are not subject to financial scrutiny by respective state, territory or Commonwealth departments of treasury and finance.

The [Victorian Government Auditor General](#) (which is currently the public sector auditor for AHPRA) is responsible for undertaking an audit of the financial statements of AHPRA only. Similarly, external accreditation councils' financial statements are separately examined by external auditors appointed by the councils. Although broader audit powers to assess performance and efficiency of public entities are accorded to public auditors within their legislative scope, there is no requirement in the National Law for performance or efficiency audits of any of the entities within the National Scheme.

In terms of internal audits, in correspondence directly to the Review, AHPRA advised:

*“The internal audit conducted by AHPRA provides independent and objective assurance to the Finance, Audit and Risk Management Committee (FARMC) and other levels of management, that AHPRA’s control environment is operating in an economical, efficient and effective manner; is compliant with relevant legislation and regulations; and that significant risks are being managed through sound control measures.*

*In meeting these objectives, internal audit assists AHPRA to accomplish its objectives by bringing a disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes across the organisation”.*

These internal audit reports are not publicly available, and it is therefore difficult to comment on the adequacy of these processes. However, if AHPRA have established internal processes to improve financial efficiency, transparency and accountability, these have not been used consistently across the National Scheme and nor have they been shared with accreditation authorities.

## Performance monitoring and reporting

The guiding principles of the National Scheme emphasise transparency, accountability, efficiency and effectiveness for all entities operating within it. The Ministerial Council has the power to issue policy directives in relation to functions under the National Law; however, none have been issued for governance, performance and accountability. Public scrutiny of the performance and functions of the National Scheme, including accreditation, has primarily occurred through this Review, the 2014 NRAS Review (both initiated by the COAG Health Council) and inquiries instigated by state and Commonwealth parliaments. These reviews may have been necessary due to the infancy of the National Scheme; however, they are not best practice for the purposes of future continuous improvement of performance and cost-effectiveness.

Irrespective of how the future governance of the accreditation system is constructed, regulators need to be accountable. Consistent and comparable reporting on, and measurement of, quantitative and qualitative performance metrics is needed. Public reporting improves public confidence, allows the regulator to be assessed and provides an incentive to improve performance.

While some necessary metrics can be found in accreditation councils' annual reports, the Review considers it important that key metrics form part of core National Scheme indicators to enable the assessment of activity and expenditure both within and across professions. The Health Care Consumers' Association in its response to the Discussion Paper submitted:

*“However, until many of the aspects of good performance sought by accreditation are built into normal business, organisations see the process of accreditation as an unnecessary emburrance –something else they need to ramp up and perform for. Such specialised ‘performances’ are the antithesis of what is really needed and produce expensive shows of accreditation performance rather than health care or education and training performance. The data needed to provide evidence for accreditation should be automatically produced from everyday performance systems with the standards actually forming part of how they do business, rather than how they do accreditation”. (DP p6)*

The Council of Ambulance Authorities provided useful proposals on potential performance indicators in its submission to the Discussion Paper:

*“Consider structural outcome and process indicators which can direct attention to (and health goals can be focused on) the patient. Provide clear pathways for Action.*

*One approach would be to look at optimal risk-adjustment models which result from a multidisciplinary effort that involves the interaction of clinicians with statisticians, as well as with experts in education, information systems and data production.*

*Given the complexity of health systems, accreditation could consider composite indicators which combine separate performance indicators into a single index or measure and are often used to rank or compare the performance of different practitioners, organisations or systems, by providing a ‘bigger picture’ and offering a more rounded view of performance.*

*Composite indicators can offer policy-makers at all levels the freedom to concentrate on areas where improvements are most readily secured, in contrast to piecemeal performance indicators”. (DP p9)*

Key performance measures should be incorporated into planning systems and investigated and acted upon when required. Both internal and external performance evaluation is critical to good governance. The HPACF submission to the Discussion Paper acknowledged the need for, and a willingness to participate in, the development of indicators that go beyond simple input and output reporting:

*“Development of KPIs related to achievement of National Law objectives, particularly health workforce reform and education innovation objectives, will need further consideration. The Forum is willing to contribute to this development. Other accreditation and regulation schemes do not seem to include these objectives explicitly. As there appears to be a lack of models to follow these KPIs would need to be developed from first principles”. (DP p24)*

National Boards and AHPRA in their joint submission to the Draft Report indicated their willingness to report against key performance indicators and outcome measures:

*“We have previously agreed that meaningful agreed performance indicators would be a helpful development and are keen to be involved in this work in addition to the performance reporting we have in place and planned”. (DR p17)*

There are also substantial opportunities to explore the linking of relevant datasets (with appropriate privacy protections) to better understand the outcomes of education and training programs (and broader domains within the National Scheme), in terms of identifying successes and providing indicators of gaps. The Review considers there would be substantial value in this data being more proactively used by entities within the National Scheme for such purposes.

AHPRA annual reports include comprehensive quantitative reporting on key registration, notification and practitioner performance output indicators, However, reporting on accreditation metrics is less consistent, both within and across the regulated professions. This may be partly due to the nature of the relationship between National Boards and accreditation authorities and differing views on responsibility for compiling and reporting on such metrics. Accreditation authority reports to National Boards are not publicly available and there is no cross-comparison of accreditation activity across the National Scheme.

The Review notes that the 2016-17 AHPRA Annual Report now includes information on accreditation activities undertaken by the three Accreditation Committees. This is a welcome first step and the Review considers that future Annual Reports should be structured to present a comprehensive report on the entire National Scheme, including all accreditation and assessment functions. The template developed by the ALG for the Costing Paper provides a useful first step on how this information could be presented.

## Recommendations

1. Funding principles should be developed to guide accreditation authorities in setting their fees and charges. The funding principles should:
  - a. be founded on transparency, accountability, efficiency and effectiveness
  - b. establish the full cost of accreditation functions performed by National Scheme entities (including the development of standards, policy advice, joint cross-professional accreditation activities, accreditation and assessment functions)
  - c. include a cost recovery policy and cost allocation methodology to guide the allocation of costs between registrants (through National Boards) and education providers
  - d. establish a consistent (accrual) accounting methodology and business principles to enable comparison across professions
  - e. require the development of a proportionately scaled Cost Recovery Implementation Statement when setting or reviewing fees and charges for accreditation activities.
2. The funding principles should be subject to wide stakeholder consultation, be submitted to the Australian Health Workforce Ministerial Council for approval and form the basis of funding agreements.
3. A set of clear, consistent and holistic performance and financial indicators for the National Scheme should be developed for approval by Australian Health Workforce Ministerial Council. They should be both quantitative and qualitative and reported on a regular and formal basis to promote continuous improvement.



## 4 Improving efficiency



This chapter explores the efficiency of current accreditation processes, including the development of accreditation standards and execution of assessment processes, and evaluates options to minimise duplication and streamline processes (where appropriate) through clarification of roles and responsibilities.

In the context of accreditation, improving the efficiency of the system is not just about reducing cost but is also about the provision of high-quality, fit-for-purpose processes that avoid unnecessary complexity, repetition and duplication, and that increase transparency and accountability.

### Key messages

Greater harmonisation of terminology, definitions, evidence and documentation across health professions could streamline assessment processes, reduce duplication, and provide opportunities for integration of resources and information and facilitate greater cross-profession education.

Delineation of health profession and institutional academic accreditation practices could streamline operations, generate efficiencies and create opportunities for collaboration with other regulators, continuous improvement, and system responsiveness.

Better prepared and skilled assessment teams, through improved training and support, could improve consistency and create efficiencies in the accreditation assessment process.

A common approach to the remuneration of assessment panel members, their travel and payment of honorariums would provide standardisation and reduce administrative costs.

### Efficiency of the current accreditation system

The Review's analysis of system efficiency addresses standard setting and assessment processes of both the education and the health professional accreditation regimes, including the roles of the regulators and the requirements placed on those being regulated. As described in Chapter 2, the accreditation of health profession programs of study and providers is a subset of the national process for the quality assurance and regulation of the education sector.

An education provider must meet the minimum acceptable requirements for the provision of education and be registered by the relevant education regulatory agency before it can deliver a program of study and bestow a qualification under the Australian Qualifications Framework (AQF). In the case of health profession education, accreditation under the National Law is aimed at ensuring a program of study meets essential education and training criteria and that graduates have the knowledge, skills and professional attributes necessary to practise the profession in Australia.

The Higher Education Standards Panel, an advisory body to the Minister for Education established under the *TEQSA Act 2011*, is examining professional course accreditation practices and opportunities to reduce the regulatory burden for higher education providers. PhillipsKPA, commissioned by the Commonwealth Department of Education and Training, delivered [Professional Accreditation: Mapping the territory](#) in 2017 which highlights the value of professional accreditation for quality assurance and improvement. While its remit was broader than health profession accreditation, one of the key issues highlighted in the final report was that:

*"... the aggregate effect of coping with idiosyncratic and excessive or unreasonable demands for information and compliance from some accrediting agencies is significant, expensive and problematic. ... Specific problems that were commonly cited by providers include the regulatory and financial burden, the wide variation in format and type of information required, inappropriate intervention in institutional autonomy, lack of transparency and due process and poorly prepared accreditation panels". (p7)*

In respect of the health workforce, the legislated guiding principles for the National Scheme (which applies to both accreditation and registration) include a requirement that it operate in a transparent, accountable, efficient, effective and fair way. Systematic application of these principles to the accreditation system would generate considerable benefits, including:

- reduced regulatory burden
- a focus on continuous improvement in operations and system performance
- best use of expertise and appropriate allocation of accountability and responsibility
- greater alignment of administrative processes across professions and with other regulators
- creation of economies of scale through sharing of knowledge, data, information and resources.

While there are examples of initiatives that are already going some way to achieving these benefits, feedback from stakeholders and the Review's analysis of accreditation authority processes reveals ongoing inefficiencies in the current system. Some of the inefficiencies include duplication of standards assessment and reporting, inconsistent terminology, and multiple assessment bodies collecting similar (or even the same) information. The numerous accreditation entities and varying requirements and timeframes create a significant workload for all education providers, and this is exacerbated if they teach multiple disciplines, including both registered and unregistered professions. As noted in Chapter 3, some education providers are employing staff, incurring costs and diverting management attention to specifically manage health professional accreditation, in addition to their responsibilities under the *TEQSA Act 2011*. Box 4.1 provides two case examples.

#### Box 4.1 Case studies – System inefficiencies

##### Australian Council of Deans of Health Sciences

*“In the Faculty of Health and Medicine at University A, there are 12 accredited health professions, with a further four health professions at the university, but outside the Faculty. Each health discipline and the School in which it is located takes the bulk of the responsibility for the accreditation of their degree. This means there is little sharing of information when addressing the accreditation standards. Where information is shared, each accreditation body requires that the same information be presented in a different format, so the opportunity to share information in a meaningful and straightforward manner is lost. Some of the information required is discipline-specific but much of the information required is institution-specific, therefore greater consistency and commonality in the development and application of the standards would allow a more institution-wide approach to completing the required documentation. This will save money and time. It will also encourage the sharing of information and information-collection tools between accreditation bodies, which should result in the development of a sensible template for entering information rather than the variety of templates used currently by accrediting bodies, some of which are poorly designed and almost impossible to complete”. (DP p5-6)*

##### Edith Cowan University

*“To provide some context, in one year from March 2016 to March 2017, ECU submitted accreditation documentation (new or renewal applications and/or annual reports) to 12 different health and health-related accreditation authorities in Australia. Each of these submissions required similar information, with supporting evidence, on operational matters including university governance; academic policies and processes; quality assurance regimes; financial probity; staffing resources and professional development; student support facilities and resources; occupational safety and health, risk and insurance policies and processes; adequate physical infrastructure and teaching spaces; and IT facilities and support. Additionally, many of these operational matters are reflected in the Higher Education Threshold Standards which universities are required to comply with to retain their self-accrediting status”. (DP p5)*

## Health profession accreditation standards: a catalyst for system efficiency

An accreditation standard for a health profession, as defined in the National Law (s5), is:

*“a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia”.*



The 14 accreditation authorities each develop, maintain and review profession-specific standards. To provide direction for the process of developing the standards, AHPRA created a guidance resource for accreditation authorities [Procedures for the development of accreditation standards](#) (2014) which describes the requirements for consistency across procedural elements and consultation processes in accordance with s46(2) of the National Law. The Procedures also note that development must take into account COAG's principles of [best practice regulation](#) (2007, p4) and consider international standards and statements.

Accreditation standards are generally reviewed every three to five years. The review process, which can take up to 24 months, includes detailed consultation, alignment with COAG processes and the requirement for National Board approval. Currently all health professional accreditation standards are at different points within their review cycles and, as such, it is likely that there is more than one review occurring at any one time.

Neither the National Law nor AHPRA documentation provide guidance on the structure of an accreditation standard. Each of the 14 accreditation authorities independently coordinate, develop and configure their own standards. In all cases, accreditation standards are constructed with high-level, thematic domains, with a number of underpinning, specific elements detailing the requirements for the education provider or program. While increased uniformity has occurred since the National Scheme was established, many of the existing standards vary in structure, content and terminology.

## Mapping accreditation standards

The Review conducted a high-level mapping exercise across health profession accreditation standards which revealed broad areas of commonality across domains, with specific contextual references to the profession in the underpinning elements. To determine the level of consistency, The Review's analysis categorised the domains into seven common themes:

- **Corporate governance:** Requirements for an education provider to operate as a viable, responsible and financially sustainable entity, with policies and procedures relating to corporate governance, monitoring, accountability and information management.
- **Academic governance and quality assurance:** Requirements for policies and procedures to ensure academic integrity, research quality and robust educational philosophies that inform high-quality course development, design, monitoring, quality improvement and risk management for a program of study.
- **Student experience:** Appropriate policies and procedures relating to the student experience at the education institution. Includes diversity and equity, wellbeing and safety, fitness-to-practice, student grievances and complaints and feedback processes. Also references requirements for clear program information for students including admissions, credit and recognition of prior learning, orientation and progression, and information for prospective and current students.
- **Program design and curriculum development:** Program design ensures learning outcomes align with the professional competency standards. Includes requirements for interaction with students, the health sector and society, and to ensure external entities are engaged to inform program design and content.
- **Learning resources:** Requirements for appropriate learning resources including physical facilities and infrastructure, and qualified staff to deliver the program of study.
- **Student assessment:** Methods of assessment are comprehensive, fair, valid and reliable. There is a robust relationship between learning outcomes and assessment strategies.
- **Clinical experience:** Requirements at the work experience location, including quality and safety policies and processes, informed patient consent procedures, and suitable work-based and clinical learning facilities. Also specifies requirements to achieve the learning outcomes and to develop student competence to practise, appropriate duration and quantity of placements, and a supportive learning environment.

From this analysis, there are a number of key observations:

- Domains from all profession-specific standards can be allocated to these high-level seven themes. This confirms that there is scope to improve the consistency of accreditation standards and resulting assessments across all professions.
- Any one domain from a profession-specific accreditation standard can include assorted elements. In this analysis, this resulted in the same domain being mapped to more than one theme, which could indicate an opportunity for greater specificity and clarification.

- Terminology for the same concept varies widely across health professions (such as program of study, program attributes, the curriculum, course content, curriculum content and sequencing etc.).
- The main differences between standards were most evident in relation to program and curriculum content and education practices, with varying references to the use of simulation, supervision requirements, hours of clinical placements and interprofessional practice.
- The three themes of ‘Corporate governance’, ‘academic governance and quality assurance’ and ‘student experience’ typically reference academic/institutional requirements and responsibilities rather than specific program learning outcomes.
- The other four themes relate directly to professional accreditation issues such as knowledge, skills, learning outcomes and competencies that may apply across-professions (i.e. common competencies) or are profession-specific knowledge and skills.

The *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs* by the Australian Medical Council (2015) also broadly align with these seven themes, albeit from a post-graduate and vocational training environment perspective. For example, these standards reference the need for evaluation of governance structures and program management, graduate outcomes, curriculum, teaching and learning methods, assessment, monitoring evaluation and the trainee experience. Outside these themes, the standards also consider continuing professional development and the assessment of specialist international medical graduates. These standards apply across the 16 specialist medical colleges, which highlights their applicability to medical programs across different technical specialities.

Each of the specialist medical colleges also has their own accreditation standards to assess training posts. The Australian Medical Council oversees and regulates these processes. Further information about specialist medical programs is considered in Chapter 8.

## Creating consistency and commonality across standards

The mapping exercise revealed that there is a degree of consistency and commonality in the domains in accreditation standards across professions. Some submissions to the Draft Report questioned the benefits and potential efficiencies that may result from aligning domains and elements within the standards if the result was a diminution of profession-specific assessment. A sample of the various benefits and risks identified in submissions are listed below.

Box 4.2. Benefits versus risks of consistency across accreditation standards

Benefits	Risks
<p><i>Consistency and enhanced certainty of what is required of institutions and accreditation panels ... Increased efficiency where similar sets of information would only need to be provided once to a single agency (e.g. AHPRA) (Division of Tropical Health and Medicine, James Cook University, DP p16)</i></p> <p><i>Consistent language creating clearer expectations for education providers ... Common priorities may become more evident and high areas needing shared action (Occupational Therapy Council, DP p9)</i></p> <p><i>Shared data and learnings for the education provider ... Easier to undertake joint accreditation visits and/or reporting ... Inform risk-based accreditation by sharing data across accreditation authorities (Australian Dental Council, DP p20)</i></p> <p><i>Wider adoption and sharing of best practice across accreditation authorities (Edith Cowan University, DP p11)</i></p>	<p><i>Lack of profession specific input (Australia and New Zealand Podiatry Accreditation Council, DP p3)</i></p> <p><i>Loss of detail required to ensure safety and competency to practise in a specific profession ... Evidence guides outlining profession specific requirements will become quasi-standards (Occupational Therapy Council, DP p9)</i></p> <p><i>Standardisation allows for a common process, however, runs the risk of losing relevance through standards being too broad. This could be alleviated by having a broad set of aspirational standards and industry-relevant pathways for attainment (Division of Tropical Health and Medicine, James Cook University, DP p16)</i></p> <p><i>May stifle innovation in the programs but also in progressing contemporary accreditation systems (value the healthy competition between authorities to continually improve) (Australian Dental Council, DP p20)</i></p>

## Box 4.2. Benefits versus risks of consistency across accreditation standards

Benefits	Risks
<p><i>Certain expectations of newly graduated health professionals could be consistently addressed through the alignment of education programmes, such as the need for interprofessional collaboration, and cultural responsiveness (Australian Dental Association, DP p8)</i></p> <p><i>Reduced cost and time required to research standards. ... Eliminated the need to separately benchmark the requirements of other Australian accreditation councils (Optometry Council Australia and New Zealand, DP p10)</i></p>	<p><i>The main risk could be the adoption of the lowest rather than the highest standards and a standardised approach to teaching activities that does not allow for innovation or a differentiated approach (University of Newcastle, DP p4)</i></p>

In 2014, the Australian Dental Council (ADC), in partnership with the Dental Council - New Zealand, developed an accreditation standard template that included five agreed domains for all dental practitioner groups, together with core evidence requirements. This was to encourage providers to more actively engage with the process (as opposed to 'tick and flick') and reduce the volume of administration.

This has proved to be a very successful innovation, and the 'Dental Council template' is now being used (with some modifications) across an additional four of the 14 registered professional groups and is under consideration by a further four. Those who have adopted the template are the Australian Physiotherapy Council (APhysioC), the Australian Psychology Accreditation Council (APAC) the Council on Chiropractic Education Australasia (CCEA) and the Optometry Council of Australia and New Zealand (OCANZ). The Occupational Therapy Council (Australia and New Zealand [OTC]) and the three accreditation committees are also considering options to commence with this format when next reviewing and updating their standards.

Consistent with this approach, accreditation councils (and the Health Professions Accreditation Collaborative Forum [HPACF]), in their submissions to the Discussion Paper and Draft Report, were generally of the view that there were a number of benefits from having greater consistency and commonality in the development and application of accreditation standards.

## Box 4.3. Accreditation councils on common accreditation standards

**Health Professions Accreditation Collaborative Forum**

*The Forum strategic action plan includes work on efficiency ... This work includes projects on shared terminology, data collection and reporting, training materials and definitions of major change in a program of study. In this work the Forum follows the principles that consistency is desirable where there is evidence of best practice, where it is likely to lead to greater transparency and understanding of accreditation processes, and where alignment will create greater impact because processes, materials or terminology are used more frequently. (DR p6)*

**Optometry Council Australian and New Zealand**

*OCANZ supports greater consistency in accreditation standards and processes.*

*However, we recognise the need for customisation and responsiveness to material differences between professions. As one example of a material difference in process, an accreditation cycle may need to be linked to the different length of programs of study of the different health professions. It also may not be possible to achieve completely standardised data sets without adjusting for the differing sizes of professions and statistical thresholds for valid data sets. (DR p2)*

**Australia and New Zealand Podiatry Accreditation Council**

*ANZPAC generally agrees that there are opportunities for improving consistency in the development of accreditation standards. ANZPAC further agrees that there is scope to improve the consistency of the structure, content and terminology. (DP p3)*

## Box 4.3. Accreditation councils on common accreditation standards

**Australian Osteopathy Accreditation Council**

*Commonality across professions will improve the sharing of best practice across health professions and increase inter-professional coordination, liaison and development. In addition, commonality in a set of core standards across the health professions will ensure education providers maintain a similar level of quality across health programs. (DP p3)*

**Australian Pharmacy Council**

*We support having a common structure and terminology of language within standards, and will implement this for the next round of standards development. (DP p15)*

**Australian Nursing and Midwifery Accreditation Council**

*There are a number of benefits that could be achieved with greater consistency and commonality in the development and application of accreditation standards. ... In addition to the core elements, specific professional based standards would be required to reflect the specialised requirements that nurses and midwives must meet. This two-tiered system would need an overarching governance body to determine and monitor those standards that are consistent and common without losing the profession-specific requirements. (DP p1)*

**Occupational Therapy Council (Australia and New Zealand)**

*...professional input and ownership of standards is important, and for this reason, we consider there is value in developing a combination of common and profession-specific standards. (DP p4)*

**Australian Dental Council**

*The ADC believes that consistency and commonality in the approval and application of standards is where the greatest net benefit can be achieved. (DP p18)*

**Australian Medical Council**

*A potential benefit of greater consistency and commonality is the promotion of evidenced based accreditation practices but only when Australian developments are also informed by international best practice. While there is significant commonality between standards used internationally for accreditation of medical programs, there is less commonality across the standards used internationally for health profession program accreditation. (DP p7)*

The potential for, and benefits of, consistency and commonality of accreditation standards has been demonstrated by the Health and Care Professions Council (HCPC), which uses both common and profession-specific documentation for accreditation. The HCPC has developed Standards of Education and Training to assess education and training programs for 16 separate professions. A learner who completes a Standards of Education and Training compliant program is eligible to apply to the HCPC for registration. Each profession also has its own specific 'standards of proficiency', which outline the knowledge and skills a practitioner must meet throughout their career to be registered. These standards are similar to Australia's competency standards which are discussed further in Chapter 5.

Observers from an Australian accreditation authority on a HCPC monitoring visit suggested that assessment against a set of uniformly presented standards appeared to be "a tick box exercise, rather than an assessment designed to improve quality and assess strengths and weaknesses" and "there did not appear to be any capacity to raise issues related to the continuous improvement of the program, including most importantly program viability, as these issues were not 'anchored' to a particular standard". These observations highlight the importance of a robust and thorough assessment methodology and the need to ensure accreditation is strongly underpinned by a profession-specific quality assurance philosophy.

Another view on the operations of HCPC stated that "since common accreditation standards across a range of professions were introduced by the Health and Care Professions Council (HCPC) in the UK, the proportion of complaints to the number of registered health professions has risen each year". The Review investigated this suggested correlation and analysed the data provided in the HCPC [Fitness to practice annual report 2016](#). It shows that 0.62% of all registered practitioners had an allegation made against them in 2015–16, growing from 0.42% in 2011–12. This growth occurred through the inclusion of social workers in 2013, who in 2015–16 represented 26% of the total registrants and 55% of the 2,127 complaints received. Importantly, the HCPC

report states that the number of cases closed without the need for formal investigation grew by 59% from 2014–15 to 1,661. From this further analysis, the Review has found no link between the adoption of common standards and the number of complaints against health professionals.

Wide-ranging consultation in the development and review of accreditation standards provides the opportunity for stakeholder input and buy-in, but also incurs costs. A level of consistency and commonality of domains/elements could streamline these processes and, additionally, strengthen a sense of common purpose and collaboration across health professions.

The benefits arising from a collective approach to the development and review of standards, however, can be significantly limited by the requirement for separate and independent approval of the standards by National Boards. As noted by the Australia and New Zealand Podiatry Accreditation Council (ANZPAC):

*“Even when collaboration has occurred at the accreditation authority level, this could be undone at the National Board level when Boards approve an accreditation standard. There is also no mechanism in the current legislative or regulatory framework to accommodate cross-profession consultations and common topics such as prescribing of scheduled medicines”.* (DP p4)

The Review concludes that there are significant benefits in having a cross-profession and collaborative approach to the development and review of accreditation standards, whilst maintaining profession-specific requirements. The use of common terminology and definitions, among other reforms, would also lead to efficiencies in the accreditation assessment process. However, while there is general agreement on the benefits among accreditation authorities, and sound initiatives such as the ‘Dental Council template’, current governance arrangements do not facilitate the collective reform of the standards. This issue is explored in Chapter 7.

## Accreditation in the education sector

Although health profession accreditation and education sector regulatory authorities have different foci, many of their underpinning principles, such as quality assurance and improvement, are the same.

All AQF qualifications issued by education providers are quality assured through regulated processes that apply to all health profession programs of study including registered and unregistered professions. Specialist medical and intern training programs are external to the AQF and are thus not within the purview of TEQSA and ASQA.

### *Higher education regulation and accreditation*

TEQSA, as the national higher education regulator, ensures higher education provider compliance with the Higher Education Standards Framework ([Threshold Standards](#)) 2015. The Threshold Standards outline “*the minimum acceptable requirements for provision of higher education in or from Australia by higher education providers registered under the TEQSA Act 2011*”. They are designed to be applied at multiple levels encompassing classifications of higher education providers and provider registration, provider categories and individual course accreditation.

The Threshold Standards have seven elements which, as can be seen from their titles below, have some degree of alignment with the seven themes that are addressed in the health accreditation standards referred to earlier:

1. Student participation and attainment
2. Learning environment
3. Teaching
4. Research and research training
5. Institutional quality assurance
6. Governance and accountability
7. Representation, information and information management.

As noted in Chapter 2, the *TEQSA Act 2011* provides that higher education providers that meet specific criteria, including those registered in the ‘Australian University’ category, may be granted ‘Self-Accrediting Authority’ status. This authorises the provider to self-accredit one or more of its courses of study against the Threshold Standards and determine, within the confines of the AQF, the level of the qualification for a program of study and the length of the course.

The Threshold Standards establish an important distinction between TEQSA's role and responsibilities in regulating 'provider registration' and the role played by entities with 'self-accrediting authority' status in determining 'course accreditation'.

Self-accrediting institutions have internal governance bodies that are responsible for reviewing and accrediting courses every five to seven years, with an annual performance monitoring process. This is undertaken by teaching and learning committees (or equivalent) and approved by institutional academic boards and associated governance processes. There is a cascading series of bodies and comprehensive processes from the academic boards and their committees down through schools and faculties to individual discipline groups and centres to ensure that the Threshold Standards are maintained at the level of individual courses and programs of studies. For providers without self-accrediting authority, TEQSA completes the course accreditation assessment process against the Threshold Standards.

TEQSA plays an important role in the global quality assurance and regulation of Australia's higher education sector. In addition, TEQSA has been progressively seeking to improve its relationship with professional bodies that have a mutual interest in maintaining and improving quality in the provision of higher education in Australia.

### *Vocational education and training regulation and accreditation*

As the national regulator for the VET system, ASQA's role is to ensure that courses and training providers meet nationally approved quality standards. All VET providers must achieve the [Standards for Registered Training Organisations \(RTOs\) 2015](#) to be registered as an RTO. These standards form part of the [VET Quality Framework](#) which also includes the:

- Australian Qualifications Framework
- Fit and Proper Person Requirements
- Financial Viability Risk Assessment Requirements 2011
- Data Provision Requirements 2012.

RTOs must maintain registration and ASQA may grant this for a period of up to seven years. An RTO has a defined 'scope of registration' which specifies the training products for which it is registered to issue AQF certification documentation. To comply with the Standards, an RTO must demonstrate for all of its scope of registration that it has the capacity to deliver these training products, including evidence of sufficient trainers and assessors, education and support services, learning resources and facilities, and that it meets all requirements specified in the Training Package or VET accredited course.

ASQA can delegate high-performing RTOs with the ability to manage their own scope of registration. These RTOs must comply with the VET Quality Framework throughout the [Delegations Agreement](#). This includes conditions requiring systematic performance monitoring and evaluation of institutional practices, and organisational policies and procedures, guidelines and other documentation that outline how the RTO's own monitoring ensures the quality of its education and training.

As outlined in Chapter 2, nationally recognised VET qualifications are included within Training Packages, which are developed through national consultation. Where a qualification is included within a Training Package, ASQA does not accredit the qualification but evaluates the performance of the RTO against the VET Quality Framework. RTOs are required to make an annual declaration on compliance and submit data requirements as detailed in the Framework.

## The health profession - education interface

Since the establishment of the National Scheme in 2010, significant national reforms in the education sector (as outlined in Chapter 2) have provided opportunities for removing unnecessary duplication and more efficiently administering accreditation based on expertise and consistency across both health and education.

The Review's mapping process, referred to earlier in this chapter, included the Threshold Standards and the Standards for RTOs. As demonstrated in Appendix 5, the mapping shows areas of similarity and overlap between these education standards and the health professional accreditation standards. As previously noted, the seven common themes were further categorised into Academic/institutional and Professional groupings to distinguish between roles and responsibilities that predominantly rest with education processes and those that are directly related to the health professional learning outcomes and competencies. While the boundaries between these



academic and professional categorisations are not always clear, the concept aligns with the definitions set out in the [Joint Statement of Principles for Professional Accreditation](#) (2016) by Professions Australia and Universities Australia.

The *Joint Statement* outlines respective roles and responsibilities for an evidence-based collaborative approach and highlights that professional accreditation should:

*“be cognisant of and distinguish between the respective requirements of TEQSA – responsible for monitoring adherence to the Higher Education Standards Framework – and professional accreditation bodies – responsible for professional accreditation – and should not lead to duplication of effort or process”.* (p4)

There is general agreement that academic accreditation and professional accreditation processes are complementary and intertwined. The Threshold Standards recognise that professional accreditation is a key component of course accreditation:

*“Where professional accreditation of a course of study is required for graduates to be eligible to practise, the course of study is accredited and continues to be accredited by the relevant professional body”.* (3.1 Course design, point 5)

The HPACF references the Joint Statement in its own [High Level Accreditation Principles](#) (2016). This document seeks to facilitate a common and collective approach to the accreditation process through 12 key principles that promote working collaboratively, benchmarking against international standards, and encouraging improvement and innovation. The HPACF document states:

*“We recognise the importance of a complementary approach to accreditation processes including professional, academic and where appropriate health service accreditation to harmonise where possible and avoid duplication of effort. We support initiatives which lead to complementary approaches and better understanding of other accreditation processes”.* (p3)

However, compliance with the HPACF principles is voluntary and is based on each council’s self-assessment. Many health professional accreditation standards do acknowledge the role of academic accreditation processes by TEQSA and ASQA (as relevant). For example, the [Medical Radiation Practice Accreditation Standards](#) (2013) specifically state that they:

*“align with the threshold standards from the Higher education standards framework (Threshold Standards) 2011 (threshold HES). The Accreditation Committee recognises the role of the Higher Education Standards Panel and the Tertiary Education Quality and Standards Agency (TEQSA) in regulation and quality assurance of higher education in Australia and rather than duplicating that role, the accreditation standards will be used to assess education providers and programs in the context of assuring quality outcomes of medical radiation practice programs of study”.* (p2)

A review of the 2016 [Medical Radiation Practice accreditation guidance material](#) however, suggests that the accreditation committee still requests and assesses some evidence that has already been considered by a university with TEQSA-approved self-accrediting status (for example, financial viability and sustainability). While the distinction is acknowledged in the standards, the clarification of roles and purview of accreditation assessment appears to require further translation into practice.

Several health profession accreditation authorities now have [MOUs with TEQSA](#) to facilitate the sharing of information. These MOUs outline the basis for the parties *“to share information on matters of mutual interest”*. However, they do not consider overlap, duplication or role delegation in accreditation processes. Most importantly, the MOUs only cover information sharing with TEQSA itself and do not consider the course accreditation quality assurance process undertaken by the academic boards and their subsidiary bodies within individual institutions with self-accrediting status.

A number of responses to the Draft Report questioned whether the degree of overlap and duplication was significant, emphasising the regulatory focus of TEQSA and ASQA is on institutional registration as distinct from the accreditation authority’s profession-specific emphasis on programs of study. The Review acknowledges this concern and has addressed the issues in the following section.

## Clarification of health and education sector accreditation roles and responsibilities

The literature recognises that good governance requires the clear determination of unique roles and a collective understanding of those roles to ensure that governance bodies successfully fulfil their functions and perform their responsibilities efficiently. A lack of clarity, an overlap of functions or a misunderstanding between bodies can result in duplication of effort or critical tasks not being completed ([Uhrig Report](#), p25).

There is an important distinction to be made between institutional quality assurance which leads to provider registration, as undertaken by TEQSA and ASQA, and course accreditation quality assurance, which is undertaken by a self-accrediting education provider through academic governance bodies and processes.

As noted previously, in higher education, the Threshold Standards provide the platform for TEQSA to assess and register a higher education provider. The assessment occurs at an institutional level and encompasses matters that are expected to be delivered institution-wide either as a completed function or through governance arrangements that ensure delivery at an individual faculty or program level. So, for example, compliance with 'Student Grievances and Complaints' in the Threshold Standards would expect a whole-of-institution policy rather than for each course. Other institutional level standards ensure mechanisms exist for the requirements to be delivered at a course level and that the institution has systems in place for implementation. An example of this is outlined in TEQSA's approach to academic governance and corporate governance (which are also assessed by health profession accreditation authorities from a profession-specific perspective).

*"The overall intent of the Standards (as reflected in 6.3.1) is to establish a system of academic governance that will provide competent academic oversight and monitoring of all academic activities at the institutional level. This overarching arrangement **encompasses but extends beyond local monitoring of an individual course or unit of study, e.g. by subject coordinators, up to the institutional level**". (TEQSA Guidance Note – [Academic Governance](#)) (Emphasis added)*

*"The corporate governance Standards are designed to ensure that the matters encompassed by all other Standards in Part A of the HES Framework are intended to have a traceable accountability pathway to the governing body and Standard 6.1, via Standard 6.2. For example, the next layer of overarching Standards (academic governance and institutional quality assurance) requires the provider to generate performance monitoring information from various aspects of its operations and to report that information through its management information systems to the governing body". (TEQSA Guidance Note – [Corporate Governance](#))*

Under the *TEQSA Act 2011*, it is an obligation of registration that all registered higher education providers meet and continue to meet the Threshold Standards – from both provider registration and course accreditation perspectives. The question addressed by the Review is whether standards of the type outlined above require a second and alternative assessment by professional accreditation processes, given they have already been assessed and are monitored by the national regulator.

To explore opportunities for greater clarification of roles and responsibilities, the Review analysed the ADC Accreditation Standards (as an example) and compared them with the roles of TEQSA and institutional course accreditation processes, as specified by the Threshold Standards. Key methodological considerations in the analysis aligned responsibilities with expertise:

- TEQSA registers and evaluates the performance of higher education providers against the Threshold Standards.
- Institutional course accreditation, also assessed against the Threshold Standards, places an emphasis on pedagogical performance and assurance of academic processes for high-quality qualifications and student experience (i.e. the 'academic/institutional' group themes from the standards mapping above).
- Health profession accreditation ensures programs of study deliver National Law requirements of profession-specific knowledge, skills and professional attributes (i.e. the 'professional' group themes from standards mapping above).

The analysis revealed that approximately 75% of elements in the ADC accreditation standards were common to the Threshold Standards provider registration and institutional course accreditation regime, although noting that there may be different emphases placed on some elements being assessed and the boundaries are not always clear. The analysis is available in Appendix 6.

The Review acknowledges that this mapping and analysis applies only to the ADC Accreditation Standards, but it does demonstrate the opportunity to minimise accreditation process duplication through identification and delineation of the separate academic and professional accreditation responsibilities to those entities with the most appropriate expertise. This aligns with the goal of the Higher Education Standards Panel as noted in its submission:

*"... To this end, the Panel considers that professional accreditation bodies should only assess or consider matters that are profession-specific and not already assured by academic accreditation against the Higher Education Standards Framework under the TEQSA Act. This would result in a significant reduction in the regulatory burden experienced by higher education providers.*



*The Panel considers that some work would be needed to more clearly differentiate the areas of operational responsibility. The PhillipsKPA report suggested the development of a 'plain English' guide to accreditation responsibilities, which may be a useful starting point for this work". (DR p3)*

A number of submissions agreed that there were opportunities, as well as some potential limitations, for a more integrated academic and professional accreditation approach (Box 4.4). However, it is noted that the emphasis in most submissions on this matter focussed on the role of TEQSA and ASQA, rather than on the more cohesive course accreditation assessment processes undertaken by institutions.

Box 4.4. Incorporating TEQSA/ASQA regime accreditation assessments

#### **Faculty of Health and Behavioural Sciences, University of Queensland**

*Yes, TEQSA's role in institutional quality assurance, governance and accountability should be acknowledged and the need for evidence of compliance with TEQSA standards be removed from accreditation requirements. Maintaining the need to re-address evidence already provided to another legislated body is redundant and costly in terms of resources for both the accreditation body and the higher education institution. (DP p1)*

#### **Faculty of Medicine Nursing and Health Sciences, Flinders University**

*The recognition of TEQSA decisions should be prima facie evidence for accreditation. This would mean that any criteria already satisfied for TEQSA and the Higher Education Standards Framework should not need to be replicated for accrediting authorities. This would significantly reduce the burden for universities of multiple overlapping regulatory regimes. (DP p1)*

#### **Faculty of Pharmacy, University of Sydney**

*For some disciplines, it might be appropriate that accrediting bodies rely more on TEQSA for evidence, thus reducing duplication. For others, particularly those with clinical, experiential or practical aspects, information gathered by TEQSA may not be fully sufficient (or appropriate) to ensure maintenance of professional standards for the discipline. (DP p1)*

#### **Medical Deans Australia and New Zealand**

*Medical Deans acknowledges the accreditation burden for education providers is high and would support opportunities for evidence from TEQSA reports to be accepted in response to some more generic standards, for example some of the standards in learning and teaching, assessment, students support and the non-clinical learning environment. However, the TEQSA reports will not address many central aspects of primary program accreditation relevant to the health professions such as Aboriginal and Torres Strait Islander or rural quota admission pathways or cross-organisational clinical staff and clinical teaching facilities in public and private and community and hospital settings. (DP p3)*

#### **Australian Council of Deans of Health Sciences**

*Incorporation of TEQSA/ASQA assessment and relevant decisions has potential to simplify reporting. It would also reflect TEQSA/ASQA areas of knowledge and specialization that program accreditation panels may not possess. Incorporation of the TEQSA/ASQA findings could enable the program assessment teams to concentrate on areas of professional capabilities. There would be a reduction in duplication and less resources wasted by not including the work done by these regulators. (DP p7)*

Greater collaboration between health profession accreditation authorities and the institutional academic course accreditation processes in universities with self-accrediting status and quality assurance systems in RTOs could minimise costs and administrative burdens for all entities. Efficiencies gained may include standardised annual data collections and reporting requirements, aligning timeframes for, and jointly undertaking or reciprocally participating in, cyclical course accreditation processes and collaborative engagement with stakeholders such as consumers, students, peak bodies and governments to inform curricula and programs of study.

The submission to the Draft Report from TEQSA acknowledges the benefits of streamlining activities:

*"One possible future focus is for all professional bodies and bodies to be on the same review cycle. ... Aligning all cycles could contribute to the further harmonisation of accreditation processes, ...*

*Another initiative could be to develop one data collection across all health related industry bodies which further enables all accrediting bodies to consider data on a regular basis. This centralisation of data collections under the auspices of the National Board could enable both a reduction in costs of data collection and a standardisation of data across these groups enabling the sharing of best practice". (DR p2)*

It is noted that some stakeholders have raised concern about aligning academic and professional course accreditation processes due to the varying nature of academic accreditation purposes, requirements and outcomes. The intent of this concept is not to create an additional burden, but to improve sequencing so that decisions from one accreditation process retain currency for the other.

To progress collaboration, a national working group comprising representatives from education regulators, health profession accreditation authorities and education providers should be established to develop agreed underpinning principles for the health profession and education accreditation processes. The principles should include:

- determination and delineation of the roles and responsibilities of key stakeholders (TEQSA/ASQA, institutional academic processes and health profession authorities) that best align with expertise
- delegation of functions and adoption of findings (where negotiated and appropriate) to minimise duplication
- alignment and/or sequencing of accreditation timeframes between the cyclical reviews of health profession accreditation authorities and institutional course accreditation processes
- improved transparency of accreditation processes and decisions, including publishing institutional quality assurance and course approval and accreditation outcomes
- opportunities to improve data recording and sharing mechanisms (technological interventions).

It is acknowledged that development of these principles will require robust negotiation to uphold the requirements for quality assurance and patient safety but should ultimately lead to a level of trust and acknowledgement of the skills and expertise of the respective parties. A rolling implementation, to align with ongoing review processes, is suggested to minimise additional workloads.

## The relationship with New Zealand

Several accreditation authorities drew the Review's attention to the arrangements that many have between Australia and New Zealand and wished to ensure that there was no disruption to this close collaboration or to any obligations under Trans-Tasman agreements.

New Zealand has separate processes and requirements for professional accreditation and academic regulation. The New Zealand Qualifications Authority (NZQA) undertakes a range of functions to ensure the quality of the New Zealand education system including managing the New Zealand Qualifications Framework (comparable to the AQF) and evaluates non-university tertiary education organisations and their courses. The Committee on University Academic Programmes (CUAP) exercises the powers of programme approval and accreditation for universities. The education regulatory bodies currently work closely with their professional accreditation and registration bodies on program approval and specify that academic approval must be supported by evidence of consultation with the relevant professional registration body.

The Review considers that the intent of streamlining processes, through delegated roles and responsibilities, should not disrupt the collaborative relationships or processes established by a number of accreditation authorities across the Australian and New Zealand systems. Relevant New Zealand organisational representatives should be involved in the development of underpinning principles as appropriate. The objective would be to ensure the decisions by all education regulators and accreditation authorities are concomitant, provide benefit to all parties and continue to ensure comparability in occupational outcomes as supported by the Trans-Tasman Mutual Recognition Act.

## Accreditation assessment

The World Health Organisation (WHO) identifies in its [policy brief](#) on accreditation of institutions for health professional education that:

*"... the most common approach to accreditation has three components: self-evaluation based on published standards; a peer review that should include a site visit; and a report stating the outcome of the accreditation (full accreditation, conditional accreditation or no accreditation". (piii)*

Accreditation assessment, re-accreditation and monitoring processes differ across professions in many respects, including cost, timeframes, performance reporting, data collection, templates and terminology, mode of submission and assessment panels (composition, training and remuneration). For education providers that deliver multiple health professional courses, there can be significant administrative burdens in managing the various reporting deliverables and timeframes. Added to this load are the accreditation requirements associated with education regulators and institutional academic approval processes and timeframes. roles and responsibilities.

## The cycle of assessing programs and providers

Most accreditation councils have adopted the practice of cyclical reviews of an education provider's health programs, in addition to annual performance monitoring. Reviews mostly occur every five years, with the ADC and OCANZ reviewing at seven and eight years respectively. The Australian Medical Council (AMC) has the longest potential accreditation period of up to ten years without undertaking a full re-accreditation process (six years as standard, with a possible 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 (discussed further below).

## Annual performance monitoring

Section 50(1) of the National Law requires that:

*“The accreditation authority that accredited an approved program of study must monitor the program and the education provider that provides the program to ensure the authority continues to be satisfied the program and provider meet an approved accreditation standard for the health profession”.*

Currently, each accreditation authority manages this monitoring requirement separately, through a range of data requests, templates and reporting items. This can result in an education provider having to generate similar but discrete information, on different templates, and submitting it multiple times to different accreditation authorities. Requested items may include:

- statistical information about students, such as enrolment and progress profiles and reports
- staffing profiles and changes to qualifications and teaching responsibilities
- curriculum changes including to educational goals and objectives
- changes to resources and facilities (particularly if related to clinical placements)
- revisions to teaching philosophies or methods
- changes to methods for student assessment
- financial status.

## Proposing changes to a program of study

Any changes to a health program, its delivery mechanisms or learning outcomes that represent a significant departure from the accredited course structure must be reported to the relevant accreditation authority for approval. The definition of a significant change is often decided by the individual authority and covers a wide gamut of topics, which are largely included in annual reporting. It is understood that the information is used by the accreditation authority to determine what type of action will be taken and whether it requires a re-assessment of the accreditation status and/or a site visit for closer evaluation. From an education provider's point of view, the lack of collaboration between authorities often results in inconsistent approaches across disciplines.

While monitoring and assessing change is important to maintaining delivery of high-quality programs that meet standards and objectives, it can create a lag in course revision. Some accreditation authorities require at least 18–24 months' notice before the introduction of a major change and often it is not clear whether approval by an accreditation authority is necessary before implementing changes. Further, if the re-assessment processes are unnecessarily onerous, some education providers have suggested that this is a disincentive to updating a program of study between cycles, further limiting responsiveness to opportunities for innovation.

## Cyclical and risk-based approaches to assessment

A cyclical assessment approach, with comprehensive reviews at standardised intervals, provides regularity and certainty to parties. It forms part of a continuous improvement cycle, which is particularly pertinent for health professional accreditation processes that have a key objective to protect the public. However, cyclical assessment offers little by way of incentives to providers to achieve exceptional performance and build an open and transparent reporting process with the assessors in exchange for extended accreditation.

In contrast, a risk-based approach to regulation concentrates resources and effort towards areas of greatest risk, while considering the most efficient and effective mechanisms to achieve and monitor performance and respond to priorities as they arise. This requires processes to be appropriate and proportionate to the level of risk, and responsive to the likelihood and consequence of potential issues. Risk-based processes reduce the burden of assessment and regulation for well-performing organisations.

A risk-based approach does not automatically remove the need for annual reporting (in fact, this is an important source of evidence for the risk analysis) or periodic comprehensive reviews. It does, however, aim to create a depth and breadth of information, using data from a variety of sources, to create indicators and risk profiles for performance and quality monitoring. As noted by the AMC:

*“Effective accreditation processes rely on collection of accurate data and information to bring objectivity and rigour to processes. A key trend in accreditation in Australia and internationally is the strengthening of collection and analysis of data on which accreditation related-decisions are based. This entails reviewing of accreditation data collections as accreditation standards are reviewed, negotiating access to relevant data held in other systems (such as the Tertiary Education Quality and Standards Agency), and advocating for or commissioning new data collections (such as the proposal for a National Training Survey for all postgraduate/vocational medical training)”. (DP p4)*

Notifications data collated by AHPRA could also be incorporated into a broader data analysis as part of a risk-based approach. The joint National Boards/AHPRA submission notes:

*“Monitoring outcomes and notifications data could be used to identify specific risks requiring more specific engagement with the provider and other key stakeholders. For example, clusters of notifications that relate to specific programs of study or providers could inform specific monitoring or themes in notifications that identify aspects of practice could be highlighted to education providers. In addition, there may be a need for a more comprehensive assessment of all programs after new or revised accreditation standards are introduced, particularly if the changes relate to higher risk areas”. (DP p4)*

The approach to risk management is variable across accreditation authorities, while both TEQSA and ASQA use a standards and risk-based approach as part of their quality assurance activities to monitor the performance of institutions, as detailed below.

### Health profession accreditation authorities

While a range of approaches is adopted, the Australian Pharmacy Council (APC), Australian Nursing and Midwifery Accreditation Council (ANMAC) and the three accreditation committees indicate they are currently using a risk-based approach.

- APC has adopted a risk-based cyclical approach, where the length of the cycle depends on a number of risk factors identified in their Risk Decision-Making Framework. Risk is determined by evidence of compliance with accreditation standards. It is noted that the maximum accreditation period is six years for organisations that are categorised as low risk.
- ANMAC has recently transitioned to a risk-based approach. In their 19 September 2017 [Communiqué](#), ANMAC notes that this will be gradually implemented in recognition of the change and to facilitate review and monitoring for a continual enhancement of the process. Based upon *ISO 31000:2009 Risk management – principles and guidelines*, the process identifies three components to its approach: risk assessment; accreditation; and monitoring.
- The three accreditation committees currently use a risk management methodology for monitoring and review. As noted in the Frequently Asked Questions section on each of the committees’ web pages:

*“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”.*

While the National Law requires accreditation authorities to monitor programs of study, it does not specify regular cyclical reviews. The rationale for the different approaches to cyclical assessment across accreditation authorities appears to be historical. The Joint National Boards/AHPRA submission has advised they are “*working to identify effective risk indicators and different monitoring methods that can be aligned to the risk profile of standards, professions and specific providers/program*” (DP p4). Submissions to the Discussion Paper noted that the ADC is considering adopting a risk-based approach and OCANZ, in partnership with the OTC and CCEA, is currently developing a common risk-based framework.

While there appears to be efforts to streamline assessment processes and focus on risk-based approaches to re-accreditation and monitoring, a collaborative approach to determining timeframes and cross-professional requirements that apply to all accreditation authorities has not been established.

#### *TEQSA’s Risk Assessment Framework (2016)*

TEQSA’s [Risk Assessment Framework](#) (RAF) aligns with its principles of reflecting risk, proportionality and necessity, as specified in the *TEQSA Act 2011*. The RAF notes that TEQSA’s risk assessments are not designed to evaluate compliance with the Threshold Standards, but to identify potential risks through a structured and systemic approach. It also states that “*TEQSA’s risk assessments are predominantly focused at the institutional level, but may also consider risks relating to specific aspects of a provider’s operations, such as particular cohorts of students and/or areas of course offerings*” (p2).

The RAF identifies the key steps of a risk assessment process and provides detailed guidance on the standardised format and set of risk indicators that are applicable to all education providers. TEQSA undertakes a systematic approach to developing the risk thresholds based upon a variety of elements including previous performance and other related monitoring.

TEQSA has designed its approach and processes to facilitate judgements on the scope and depth of monitoring and assessment activities and, based on assessment, the nature of regulatory action that may be taken, if any. The outcome from a risk assessment informs the scope of evidence required in processes for renewal of registration or course accreditation. Higher education providers are required to report annually to TEQSA and to the Commonwealth Department of Education and Training. These entities work closely to share data and minimise the reporting burden for education providers.

#### *ASQA’s Regulatory Risk Framework (2016)*

The *National Vocational Education and Training Act 2011* requires ASQA to use a risk-based approach to reduce the regulatory burden for high-performing and compliant entities, and to ensure greater attention is placed on high-risk providers. ASQA states that it uses data and intelligence to inform judgements about interventions that promote sector compliance, improve confidence and ensure the quality and reputation of the VET sector.

ASQA uses its [Regulatory Risk Framework](#), which “*identifies and evaluates risks to the quality of vocational education and training in Australia at the macro (whole of sector system) and micro (provider) level*” (p2). System risks identified through environmental scanning, and provider risks, highlighted through reporting, are evaluated against likelihood and impact measures to determine the response required. ASQA also undertakes annual reviews to monitor performance of providers and the effectiveness of its regulatory responses.

## Merit and appropriate use of a risk-based approach

Both risk-based and cyclical approaches provide a quality assessment mechanism for programs of study and providers of those programs, as recognised by a number of submissions to the Discussion Paper.

### 4.5. Cyclical and risk-based accreditation approaches

#### **Australian Psychology Accreditation Council**

*As is appropriate, we take considerable care with new providers and new programs: paradoxically, while we wish to encourage innovation, (our proposed new standards, awaiting approval, are designed to allow providers greater freedom to innovate) an unusually innovative program would inevitably come under greater scrutiny, as is consistent with a risk-based approach. (DP p16)*

#### 4.5. Cyclical and risk-based accreditation approaches

##### **Australian Pharmacy Council**

*Our view is that continuous monitoring without an accreditation cycle could indeed result in a greater burden for education providers, due to an apparently continuous requirement for change reporting; this could be an unintended consequence. (DP p16)*

##### **CQUniversity**

*A risk-based approach that involved continuous monitoring through annual report analysis and feedback and analysis of relevant institutional data would be a more effective use of resources than a full, periodic review of every program regardless of its risk profile. Robust monitoring can identify education providers, programs or areas of risk. (DP p3)*

##### **University of Sydney**

*We recognise that regular cycles of accreditation do support industry engagement and reputation of professional programs and their graduates, however on balance these benefits are outweighed by the significant benefits of open-ended and risk managed accreditation cycles that assist with efficiencies for all parties. (DP p3)*

##### **Australian Council of Deans of Health Sciences**

*Adoption of risk based approaches requires incisive understanding and description of what constitutes or flags a risk within the accreditation system and how much system penetration is required to identify false positives. Unless both are clearly described, there is a significant risk of delayed identification of problems that may be occurring in a higher education provider's program. (DP p10)*

##### **Department of Health and Human Services Victoria**

*Such a shift relies on much better data about the operation of the accreditation system than is currently available, and far stronger monitoring of the performance of education providers. Sometimes a shift to a risk-based approach has been used as a justification for reducing resources, leaving providers to self-regulate without sufficient oversight. Public confidence in the quality of graduates relies on a robust accreditation system. The current fragmented accreditation system does not provide the capability to generate with sufficient timeliness the data needed to inform policy decisions of this nature. Without governance reform, the potential for evidence informed design and delivery of the accreditation functions (for example, with respect to the length of accreditation cycles) is unlikely to be realised. (DP p2)*

##### **Australian Physiotherapy Association**

*We do not support a model of accreditation that excludes cyclical assessment processes. Accreditation councils are set up to have the training and experience to recognise risk within a physiotherapy program, where-as university program staff are experts in their areas of physiotherapy, education and learning. A combination of cyclical and risk based accreditation is already working within the physiotherapy accreditation system and this approach should be strengthened and harmonised across the professions. (DP p3)*

While the Review sees no merit in open-ended risk-based assessments in a regulatory system of such importance, risk-based methodologies not only improve the allocation of assessment resources but have significant potential to streamline the reporting requirements associated with the annual monitoring and periodic comprehensive reviews. As currently used by a number of authorities, including TEQSA, ANMAC and the APC, a risk assessment with appropriate indicators can identify providers or courses at high or low risk. Having comprehensive data with high relevance, integrity and timeliness and cross-professional sharing and analysis is critical to conducting appropriate and efficient accreditation processes.



## Consistency and commonality in data collection and analysis

Regardless of the approach adopted by accreditation authorities for performance monitoring of programs of study, consistency and commonality in the information requested can reduce the reporting burden of education providers and improve the reliability of the quality assurance process. Universities Australia, in recognising this issue, suggested that:

*“Some efficiency could be brought to bear by ensuring that terminology for common questions is standardised across disciplines and/or grouping common questions into a core set across the health professions that only need to be assessed once within an institution or used for different courses as relevant”. (DP p3)*

The Review has examined the monitoring and reporting requirements of accreditation authorities. Some accreditation authorities provide guidance on their websites and others refer to a template that is sent directly to education providers. The wide variety in style and terminology of questions, data requested, templates and submission mechanisms (online vs. paper-based) reinforces the conclusion that there is a high impost placed upon education providers to maintain health professional accreditation. Australia Catholic University provided a detailed example of the practices required for some assessments:

*“For example, some accreditation agencies require universities to provide multiple copies of the same appendices for double degrees in both hard and soft format. This requirement consumes considerable faculty staff time and cost in printing, compiling, binding and mailing the thousands of pages of the same volumes of appendices. This is an example of duplication and inefficiency imposed by agencies that are involved in the accreditation of only one component of a double degree”. (DP p4)*

Some accreditation authorities advise they are moving to online systems for reporting, which has the potential to reduce administrative requirements and costs. As noted by Western Sydney University, *“the introduction of online reporting capabilities would be of benefit in terms of improving efficiency”* (DP p1). Collaboration on online systems, including the development of common reporting indicator templates in electronic form would further improve efficiency.

Analysis of reported data informs risk management and quality assurance. Currently accreditation authorities assess the individual profession-specific aspects of the program of study or education provider in isolation from other authorities. Shared knowledge may improve the identification of more systemic risks or issues across a faculty, school or institution.

A National Academies of Sciences, Engineering and Medicine [workshop](#) ‘Exploring the Role of Accreditation in Enhancing Quality and Innovation in Health Professional Education’ noted *“Innovation in accreditation ... requires capturing data once and using it many times”* (p91). Implementation of a single data repository that accreditation authorities and AHPRA could use to upload and view real-time data could:

- standardise terminology across documents and entities
- eliminate much of the duplication in reporting and accreditation assessment
- integrate data from multiple sources to provide an overarching and comprehensive view of the health education and training system
- facilitate identification of broader issues and emerging risks; currently limited by disparate data sets.

Issues of privacy and commercial-in-confidence information will likely be raised as barriers to this approach. However, a system could be established to ensure users only have access to material relevant to their roles and responsibilities within the accreditation system.

As a future goal, an accreditation system-wide data set, with information from accreditation authorities, education regulators, AHPRA and the Australian Commission for Safety and Quality in Health Care, has the potential to greatly improve the efficiency and effectiveness of accreditation processes through a more holistic approach to data analysis and promotion of best practice and shared learnings.

## Conduct of assessments

There are various parties and processes involved in an accreditation assessment. While the specific requirements and details of assessments vary across health professions, analysis of their processes identifies that the key steps appear largely consistent and include:

- notification or invitation from an accreditation authority to an education provider to apply or re-apply for accreditation
- self-assessment and development of an application by the education provider that addresses the accreditation standards
- establishment of an assessment team by the accreditation authority for consideration and review of the application
- a site visit to the education provider and evaluation by the assessment team
- development of a draft report, including accreditation recommendations, by the assessment team – provided to the education provider for comment and final report to the accreditation committee of the accreditation authority for consideration
- final report developed by the accreditation committee, including recommendations, provided to the Board of the accreditation authority for final decision
- notification of decision to education provider and to National Board for consideration of the accredited program of study as providing a qualification for the purposes of registration
- publication of National Board approved program of study on the AHPRA website.

## Assessment team formation

The [Quality Framework for the Accreditation Function](#) (2013) specifies that:

*“...an accreditation authority has policies on the selection, appointment, training and performance review of assessment team members. Its policies 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”. (p5)*

An assessment team (also known as site evaluation team or panel) is formed by the accreditation authority. Its tasks include:

- reviewing the self-evaluation report completed by the education provider
- visiting sites (often over multiple days) to confirm information provided in the self-evaluation report and collect additional information about facilities, teaching staff, corporate and student records, and program and curriculum details
- developing an assessment report and proposing recommendations and reasons for accreditation status.

Assessment teams commonly consist of practitioners (with academic and clinical experience), educationalists and, in some cases, students. In assembling a team, consideration is given to ensuring a balance of educational knowledge, experience, geographic location, clinical disciplines, employer setting and employee status. Some professions have a list or register of approved assessors that may be appointed to undertake an accreditation assessment; others indicate the likely composition of the team or panel. For example:

- **ANMAC Register of Accreditation Assessors:** the [Assessor Handbook](#) notes that ANMAC selects and approves assessors based on current knowledge, skills, expertise and experience, and their standing in the nursing and midwifery professions. Nurses and midwives must hold current registration in Australia.
- **Aboriginal and Torres Strait Islander Health Practice Accreditation Committee:** the list of approved [accreditation assessors](#) comprises persons who:
  - a) are a registered Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker
  - b) have current experience in delivery of the Aboriginal and Torres Strait Islander primary health care practice and experience in clinical education and workplace training
  - c) have sound knowledge of education and experience in teaching and learning.



- **OCANZ:** the [Process and Procedures manual](#) (2012) states assessment teams usually comprise:
  - a) three senior academics from optometry schools other than the school undergoing assessment, one normally from overseas; heads of the Australian and New Zealand schools are not usually appointed.
  - b) three distinguished and experienced practising optometrists, at least one residing in the state (or country if there are no states) of the school undergoing accreditation.

The practice of including other professions or sector representatives (such as employers, students, government) on assessment teams varies across accreditation authorities. A more inclusive approach has the potential to improve cross-professional interaction, increase transparency, promote the value and inclusion of diverse perspectives and may facilitate the accreditation of health schools within education providers, rather than individual profession-specific programs of study. As noted by Edith Cowan University:

*“As a general principle, broadening the representation on accreditation panels would reflect and promote a better understanding of the links between teaching, learning, research and clinical practice, and how they influence the further development and improvement of teaching standards and graduate outcomes”.* (DP p7)

However, to establish this protocol, guidance is required around best practice development and structure of assessment teams to ensure appropriate and diverse skills-based representation while maintaining profession-specific competency as required. Recognising that costs potentially increase with the size of a team, any such direction would need to balance the need for skills diversity with sufficient profession-specific expertise. The inclusion of consumers on assessment panels received mixed opinions from the various submissions. Further analysis of consumer involvement is explored in Chapter 5.

## Other assessment team models

As noted earlier, the HCPC uses common accreditation procedures for 16 health and social care professions. As part of this process it has established ‘partners’ who undertake a number of roles including continuing professional development (CPD) assessors, legal assessors, panel chairs, panel members, registration assessors and visitors. In particular, ‘visitors’ include registered members of professions and members of the public and, as described on its [website](#), 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”.*

HCPC assessment teams include a member from the profession and a lay member wherever possible. As part of a continuous improvement, the performance of each partner is assessed every two years through self-evaluation and peer observation.

TEQSA uses a register of experts who are expected to have and maintain significant knowledge and experience in one or more identified areas of expertise. TEQSA is currently reviewing its system to guarantee functionality and currency of the register. TEQSA does not have a prescribed training regime for its experts, although this issue is also being evaluated as part of its review.

Under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, ACSQHC does not complete accreditation processes itself but approves accrediting agencies. Further information is provided in Chapters 5 & 7.

## Improving assessment teams and processes

Education providers report that there are vast differences in the capability and competence of assessment teams and that this impacts on the amount and level of information they are required to provide. The PhillipsKPA report notes:

*“The single issue raised most commonly by providers is the inconsistency between the published position of the professional body as a corporate entity and the position of the various members of the profession (including academics) who actually perform the accreditation tasks”.* (p63)

A number of submissions also raised examples of their experience with assessment teams.

Box 4.6. Assessment teams in operation

#### CQUniversity

*From CQUniversity's experience there is great variation between accrediting authorities in terms of the application of standards frameworks in a fair and consistent manner. In some cases judgments are made by accrediting authorities to impose conditions on matters outside the scope of the accreditation standards. Some accrediting authorities also do not make it clear where a requirement needs to be imposed to ensure public safety as per National Law objectives and where a recommendation is being proposed for improvement of a program. Accrediting authorities should clearly differentiate where an action should be taken to ensure compliance with an accreditation standard and where an action is desirable to improve a program though not essential to ensure public safety. In this way the intent of the scheme to ensure public safety can be maintained along with the Quality Frameworks of facilitating quality improvement. (DP p2)*

#### NSW TAFE

*All assessment teams should have a professional staff member in their teams from their accreditation council who contribute to ensuring a common standard of assessment across accreditations. (DP p1)*

#### Heads of Department and Schools of Psychology Association (HODSPA)

*Consistency and professionalism – a number of respondents noted that the panels went beyond the written standards and engaged in conversations that were outside of their remit. These included:*

- *Standards are unclear, leading to anxiety about whether an AOU is meeting them*
- *Arguing about the AQF level of a program that TEQSA had approved at that level. This was also the case for two self-accrediting institutions.*
- *Requesting additional documentation that was not used.*
- *Asking for a position that is not set out in the standards.*
- *Not all Heads are convinced that the standards are applied consistently. They are dubious about some programs at other institutions.*
- *Stating that something meets the standards in one context, but saying that it does not in another.*
- *Ignoring the processes of natural justice when dealing with student comments.*
- *Incorrect material on the website. (DP p12)*

The preparation and training of assessment teams varies across professions, and standardisation may help reduce the variability observed by education providers.

The AMC described its training as follows:

*“The AMC’s training of teams includes written resources, buddying a new and an experienced assessor, and annual accreditation workshops, led by the Chair of the relevant accreditation committee and AMC accreditation staff. The AMC invites to the workshop: assessment team chairs and deputy chairs, new members of assessment teams, academic heads of education providers undergoing accreditation, medical students/trainees from providers undergoing accreditation. The workshop is an opportunity to learn about the experience of accreditation, consider the role of the different groups engaged in accreditation and learn the processes and techniques for site visit interviews and team evaluation of a medical program against the accreditation standards. This workshop is not only about training, but also about transparent engagement of the providers in the preparation for accreditation assessments”. (DP p11)*

The APC has also established a comprehensive training and selection process for Site Evaluation Teams (SETs), including online training modules. A summary of the modules from the APC submission to the Discussion Paper (p17) lists:

- **SET Module One** provides an overview of the APC accreditation framework, which ensures the quality, consistency and rigor of standards and audit processes

- **SET Module Two** focuses on how to prepare for a SET audit and undertake an initial assessment of an application, ready for the site visit
- **SET Module Three** outlines methods and tips to conduct an on-site audit that focuses on evidence gathering against the APC guidelines and standards
- **SET Module Four** (optional) provides techniques and tools to enable a member to contribute to the development of an evidence-based report against the APC guidelines and standards.

Training should provide opportunities for engagement and networking, as used by the AMC, and include development in skills such as communication, adult teaching techniques, future health care models, innovative approaches to health education and training (including international and national best practice models), auditing and sampling techniques, and a clear direction on the scope of assessment. This would support team members to form consistent views on documentation, evidence required and priority areas of assessment focus. The PhillipsKPA report highlights that smaller professional bodies may not have the resources to invest in development and training. As such, and where appropriate, best practice approaches and training that have been developed by other accreditation authorities (or other relevant training providers) should be employed on a fee for service basis, rather than each authority developing its own tools.

A quality assurance process for monitoring the reliability of assessment teams and experts should also be considered. As currently used by HCPC, options could include a regular self-assessment or peer review of assessors and standardised reporting templates with greater clarity and consistency in terminology. Quality assurance may be further enhanced by an electronic reporting tool to collect and collate information, which could also create opportunities for data integration across professions.

The Review considers that the establishment of a register of experts, available to all health profession accreditation authorities, is one option that would provide access to the expertise of other professions and sectors for inclusion within assessment teams. It would also enable the maintenance of a record of the training and performance of assessment team members. Accreditation authorities could be responsible for nominating and managing the proficiency and appropriateness of experts on the register in their profession and could nominate other suitable experts, such as educationalists, employers, students, government etc. Establishment of a register should allow:

- accreditation authorities to retain control over the selection and establishment of assessment team members
- profession-specific expertise on assessment teams and cross-profession access to broader knowledge and skills through a list of appropriately trained experts (if deemed appropriate for assessment team composition)
- a central repository for recording assessment team member training and performance
- a platform to share best practice findings and evidence.

Accreditation authorities should also support further research to explore best practice options for the ideal skills and expertise required for panel composition. A key objective should be to achieve interprofessional collaboration and ameliorate the impact of accreditation assessment silos.

## Remuneration of panel members

Accreditation authorities have varying policies that guide remuneration, travel arrangements and honorariums paid to assessors. Some authorities align payment with the [Remuneration Tribunal](#) (an independent statutory body that handles the remuneration of certain Commonwealth officers) and others establish their own rates. Some authorities have a lump sum arrangement while others base their payments on the number of days worked. Assessors are also paid honorariums for undertaking onsite assessments, which cover meals, accommodation and travel expenses. Accreditation councils factor in the cost of remuneration, honorariums and travel expenses in the fees charged to education providers and overseas trained practitioners and in their funding requests to National Boards.

In addition to the respective policies of the accreditation councils, AHPRA also has remuneration and travel policies that apply to its staff, National Boards and the three accreditation committees. AHPRA fees for committee members are based on the Queensland Government [Remuneration](#) of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities and have been approved by the Australian Health Workforce Ministerial Council.

The Review compared the fees paid to panel members by accreditation councils against the AHPRA Schedule of Fees. Daily fees paid by the Chiropractic, Dental, Nursing and Midwifery, Osteopathy, Pharmacy and Psychology accreditation councils to assessment panel members were within the benchmark or lower than the sitting fees paid by AHPRA. The AMC aligns its payments with the Commonwealth Remuneration Tribunal and are similar, albeit slightly higher than the AHPRA fees. The Review was unable to assess the fees paid by ANZPAC and OTC as these were lump sum payments and not based on the number of days worked. The Review did not receive remuneration information from APhysioC.

It is administratively inefficient for each accreditation authority to develop (and annually update) its detailed policies on remuneration and travel. It also adds to the difficulty of making any comparison or benchmarking of accreditation costs. To enable greater consistency and reduce administrative cost, the Review proposes that there be a common approach to the remuneration of assessment panel members, their travel and payment of honorariums. The Review does not, however, consider it appropriate to make recommendations on how these payments should be set.

This Review has not considered the payments paid to members who sit on accreditation council governance boards. These are matters for the accreditation councils, which are independent, not-for-profit registered companies.

## Recommendations

4. Cross-profession policies and guidelines for the development of accreditation standards and the conduct of assessment processes should be established to require:
  - a. Standardised terminology and definitions across the accreditation process
  - b. Agreed cross-professional domains and elements, in addition to existing profession-specific requirements, for inclusion within standards
  - c. A common reporting framework that sets out uniform requirements for education providers and includes consistent risk indicators, standardised data collection and collaborative use of information technology approaches.
5. Clarification of academic and professional accreditation should be agreed between education sector regulators, institutional academic governance bodies and health profession accreditation authorities. Implementation should be achieved through mutual recognition of the respective roles and responsibilities of regulators, adoption of accreditation findings and outcomes from recognised regulatory processes, appropriate sequencing of accreditation processes and improved data sharing.
6. Cross-profession policies and guidelines should be established to improve the quality and performance of accreditation assessment teams through:
  - a. a standardised approach to their training and preparation
  - b. a self-assessment or peer review process for monitoring their performance
  - c. a common approach to their remuneration.

## 5 Relevance and responsiveness of education



This chapter explores the constraints and opportunities within the existing accreditation system in delivering relevant and responsive health education programs that align with the National Scheme objectives and address health workforce priorities.

### Key messages

The consumer voice is central to the design of education and training programs which promote patient-centred health care.

Outcome-based accreditation standards can more flexibly respond to evolving community health care needs, changing technology and innovations in health practices.

A consistent approach to the development of competency standards, including agreement on common cross-professional competencies and with references to the NSQHS Standards and Cultural Safety, will deliver relevant knowledge, skills and professional attributes for patient-centred care.

Greater leadership and cross-professional support from accreditation authorities is required to drive improvements in:

- interprofessional learning and practice, through principles and guidelines for implementation and accreditation assessment, to improve the uptake of team-based care
- adoption of principles which ensure clinical placements are reflective of future service models and workforce priorities
- responsive accreditation standards and assessment processes which support evidence-based technological and pedagogical advances being incorporated in the delivery of programs of study.

National Board decisions to impose additional requirements for pre-general registrants to demonstrate their ability to practise should require justification and scrutiny.

Where internship programs are established as vocational training programs, they should be formally recognised as programs of study and be subject to monitoring and oversight by the accreditation authority.

A robust accreditation process should negate the need for national examinations for domestic trained practitioners.

### The centrality of consumer perspectives

Consumers should be able to expect that the health care system and its workforce are driven by the public interest, are fit for purpose and are responsive to the community's health care needs. The National Scheme should ensure that graduates have the knowledge, skills and professional attributes to respond to evolving health care needs, that standards maintain their currency, and that education programs are contemporary and innovative. As noted in one consumer's submission:

"Accreditation processes should contribute to creating the workforce the community needs and prefers, now and into the future. This includes: ... anticipating and responding to new and emerging consumer- and community-centred service models that focus on what matters to consumers: achieving safety, wellness and quality of life". (Consumer 2, DP p4)

At the Consumer Health Forum workshop in March 2017, held as part of the Review’s consultation process, one participant reflected that a health professional’s primary purpose is to “help people live well lives”. Consumers currently observe a scheme of 14 professions, each with their own National Board and accreditation authority. They are aware that siloed approaches are counterintuitive to team-based care arrangements which aim to place a patient at the centre of care to achieve a “well life”. They do not see the differences between, or need for, 14 different sets of accreditation requirements or processes. There was support at the workshop for a more responsive and effective accreditation system that encourages respect, inter-collegiality and collaboration across health professions, and greater commonality of fundamental training while retaining technical and craft-specific skills. A more unified consumer engagement process to capture the patient voice was similarly supported.

The National Law provides for community involvement in the operations of the National Boards but does not define the concept of a community member. Further, there are no specific requirements under the National Law, or under the contractual agreements with accreditation authorities, regarding community involvement in carrying out accreditation functions. As noted in the Victorian Department of Health and Human Services submission to the Discussion Paper:

*“There is lack of clarity about the concept of a ‘community member’ within the National Scheme... Some consider community members should be health service consumers with a background in consumer advocacy, and with strong links with consumer representative groups and no alliances or links, past or present, with the regulated health professions. Others see community members simply as persons who are not from the regulated profession and who bring an independence of thought and useful skills and knowledge to their role, such as in governance, the law, finances, or education and training”.* (DP p3)

There is a broad group of stakeholders who are consumers of the health care accreditation system – in effect, the beneficiaries of that system. While consumers from this perspective can include registrants and education providers, for the purposes of this Review, consumers are defined more narrowly as:

- **service users** who are patients, families and carers who use the services provided by a health professional who has received accredited education and training
- **students** who are recipients of education and training from accredited education providers
- **employers** who recruit graduates of accredited programs to provide healthcare services.

The rationale for separating service users, students and employers from education providers and registrants is that, while all derive a direct benefit from an effective accreditation system, the inclusion of the former group in accreditation functions ensures that activities and decisions are open to broader scrutiny and can withstand a ‘public defensibility’ test.

## Why include consumers?

Health systems globally are recognising the value of including the consumer voice in the design and delivery of healthcare services. Consumers are an effective safeguard to ensure that the health system is patient-centred, transparent and provides value for money for the taxpayer.

### *Service users*

The definition of what it means for healthcare services to be ‘patient-centred’ is expanding and evolving, from listening and communicating with patients to actively involving patients as partners in their health care. The National Safety and Quality Health Service [Standard 2](#) notes that delivering care based on partnerships provides many benefits for the healthcare consumer, provider, organisation and system. It further states that evidence is building about the link between effective partnerships, good consumer experience and high-quality health care, including improved clinical outcomes, decreased re-admission rates, improved delivery of preventive care services, improved adherence to treatment regimens, and decreased rates of healthcare-acquired infections.

Local and international [studies](#) have found support for this direct correlation between increased consumer-centred care and an efficient and effective health system. In terms of the accreditation system, consumers, as service users, can add value to the design and implementation of health profession education reforms. The General Medical Council (United Kingdom), in its [Guidance](#) to medical schools, noted that:

*“Patients can contribute unique and invaluable expertise to teaching, feedback and assessment and involving patients in medical education can be beneficial to learners: not only does it facilitate acquisition of skills such as communication, but it can also change professional attitudes positively and develop empathy and clinical reasoning. It provides context to the learning material and motivates learners”.* (p6)

The Health and Care Professions Council (HCPC) commissioned research on the inclusion of consumers in accreditation and registration activities. This [research](#) noted the merits of a meaningful level of service user involvement but its suggestions were more focused on the design and delivery of the programs of study rather than on accreditation processes.

Submissions received by this Review highlighted the benefits of including service users (patients, carers and families) in accreditation functions – including curriculum development, assessment panels and the development of competency standards. The Health Care Consumers Association, in its submission, noted:

*“Consumers often ask questions about issues that are about the culture of healthcare and are less affected by the unspoken norms that often guide health care practice and systems, often in ways which do not best serve patients and families ..... but which are seldom questioned inside the organisation or by professionals themselves”.* (DP p4)

Other submissions to the Discussion Paper highlighted the value that service users bring to the accreditation process in relation to diversity and cultural safety. The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives noted:

*“To ensure cultural safety and respectful practice are embedded in education and training for health professionals, Aboriginal and Torres Strait Islander communities and their representatives must be systematically engaged in curriculum planning and review for education courses and accreditation assessment”.* (DP p10)

Service users are able to identify gaps within the health system, which may not be as evident to those providing or regulating health care:

*“Consumers and Carer’s with a ‘lived experience’ are vital educators of our health professionals. The value that we can add to the overall education of health professionals and undergraduates is priceless”.* (Consumer 1, DP p3)

On the other hand, several submissions to the Discussion Paper from professional organisations considered that consumer involvement needed to be balanced with the cost and relevance of this involvement. The Royal Australasian College of Ophthalmologists stated that:

*“Given the level of complexity involved in the accreditation process, consumers should only be added to the accreditation team if they have appropriate training and qualifications”.* (DP p2)

The Australian Nursing and Midwifery Federation noted:

*“Consumer members of the ANMAC Board provide invaluable contributions to the accreditation process for entry to practice education programs for nurses and midwives ... While consumers can contribute their perspective on care requirements to the higher level accreditation standards development, they do not have the necessary discipline-specific knowledge of requirements for competent and safe practice as a nurse or midwife. We do not therefore support consumer engagement as part of the assessment team for accreditation of nursing and midwifery education programs”.* (DP p9)

Optometry Australia submitted:

*“We do not consider that there is a need for consumer representation in the specific activities of the accreditation process, where that consumer is a member of the general public or a representative from a consumer organisation. At the level of accreditation of training, consumer input is difficult to integrate as the needs of the curriculum, facilities and so on are not directed to the consumer, but to the student and ensuring their development as competent health professionals”.* (DP p4)

Consumers also have a primary stake in ensuring the efficiency and sustainability of the health system and its workforce. According to the [OECD](#), Australian consumers meet 20% of health care costs directly through out-of-pocket funding, with a further 12% being met mainly through private health insurance premiums. The remaining 68% is met by taxpayers in general, whether or not they are consumers of health care services.



## Students

Students are a second group of system consumers, as direct beneficiaries of accredited education and training programs. The *Higher Education Standards Framework (Threshold Standards) 2015* has a requirement for student feedback as part of the overall assessment of [Institutional Quality Assurance](#). Accreditation authorities, as part of their quality assurance and improvement processes, incorporate similar requirements for student input within their standards and assessments. This approach is supported by education providers, such as the CQUniversity who submitted in its response to the Discussion Paper:

*“There may be value in having student assessors from senior years as part of assessment teams to bring the perspective of current students to the assessment of a program”.* (DP p4)

## Employers

Employers have expectations that the accreditation system will ensure that graduates are work ready. Employers can provide useful feedback in terms of both the knowledge and clinical skills of graduates and of their professional attributes such as their ‘people skills’ capability. Communication skills, resilience and ability to work in teams are important features of competency standards and health education curricula more broadly. While some of these learning needs may be delivered through employer programs, employers, including clinical supervisors, can also highlight gaps in pre-vocational education and training. An individual optometry service provider in his response to the Discussion Paper noted:

*“... employers of graduates should be satisfied that the program is sustainable, produces graduates that protect the public and delivers adequate knowledge, skills and attributes to the graduates that meet current and ongoing contemporary standards of the profession”.* (Individual practitioner, DP p2)

Employers can also contribute specialist knowledge on the effectiveness and viability of clinical placement sites being assessed as part of the accreditation process.

Stakeholders provided a range of views on the importance of consumer involvement in health profession education and training.

### Box 5.1: The importance of consumers

#### Occupational Therapy Council (Australia and New Zealand)

*OTC strongly supports this recommendation, as it is consistent with OTC’s current expectation. Having the same expectation across all accreditation authorities would provide impetus for Education Providers and accreditation authorities to implement appropriate structures, support and training for meaningful inclusion of consumers. It should be recognised that this may have additional cost implications for the scheme, but it is a critical component to a comprehensive and accountable accreditation system.* (DR p5)

#### Australian Dental Council

*The ADC already expects dental practitioner programs to demonstrate how external feedback to the program is incorporated into the respective programs. This is especially important given clinical placements are usually provided through jurisdictional dental health services. The ADC would welcome the opportunity to engage with the Community Reference Group regarding accreditation.* (DR p13)

#### University of Adelaide

*All accreditation standards should require education providers to demonstrate the involvement of consumers (health service users, students and employers) in the design of education and training programs, including the development of education curricula, as well as demonstrate that the curricula promotes patient-centred health care. ANS currently have a “consumer” on the Accreditation working Group as required by ANMAC.*

*The University supports the consumer voice as a means to driving higher standards and assuring quality in our programs, especially from the point of view of patient-centred simulation.* (DR p7)

#### Medical Deans Australia and New Zealand

*MDANZ supports greater involvement of consumers - it is important that students, recent graduates, employers and consumers have a role in shaping standards. Clearer process guidelines about engagement with health care service providers and consumers would be useful.* (DR p6)

## Box 5.1: The importance of consumers

**Australian College of Midwives**

*Co-creation of programs with those who will study in them and with those who are users of health care is vital for ensuring those programs reflect learners', service users' and the broader industries' needs and priorities. (DR p4)*

**NSW Health**

*NSW Health notes the need for consumer involvement in the design of education and training programs and products, however consideration of the level of involvement and at what stage is required. (DR p4)*

**National Health Practitioner Ombudsman and Privacy Commissioner**

*The NHPOPC is supportive of greater consumer involvement in accreditation functions, particularly if a broad definition of 'consumers' is taken in order to incorporate a range of different perspectives (such as the views of service users, students and employers). In general, encouraging consumer involvement will provide greater assurance that the accreditation system is transparent and responsive. (DR p4)*

## How are consumers currently involved?

Consumers currently contribute to the accreditation system through participation in a variety of forums and processes:

- **Accreditation authority governance** – representation directly on Boards or on decision-making committees
- **Assessment processes** – participation as members of assessment panels or by providing consumer feedback
- **Curriculum development** – input in the design and content of the curricula as developed by education providers
- **Development of competency standards** – participation in deliberations on scope of practice and skills requirements and ensuring alignment with modern health practices of delivering patient-centred care
- **Risk management and monitoring** – contributing intelligence to the regulatory system through complaints and notification processes and feedback during accreditation activities.

AHPRA plays an important role in supporting 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 consumers. AHPRA's [Community Reference Group](#) advises on matters related to the National Scheme, including advising AHPRA on how to better understand, and respond to, community needs.

While National Boards have the legislative authority for approving accrediting programs of study and education providers, the AHPRA Community Reference Group is not engaged on accreditation issues. The joint National Boards/AHPRA submission to the Discussion Paper notes that:

*"Currently there are varying levels of consumer/community involvement in accreditation governance and decision-making, with less involvement in assessment teams ... We have had an increasing focus on consumer involvement and engagement since the Scheme commenced. Exploring opportunities for more consumer involvement in the accreditation functions is consistent with that philosophy and direction". (DP p5)*

An analysis of individual accreditation authority constitutions, governance arrangements and assessment processes indicate there are varied approaches to the participation of consumers. Some accreditation authorities (dental, nursing and midwifery, medical, osteopathy, pharmacy, physiotherapy, podiatry and psychology) include consumer or community representatives on their boards, but in the majority of cases the consumer representatives are lawyers, academics and sometimes health service executives.

Some authorities include consumer representatives on internal committees that are convened to develop accreditation standards and review the assessment of programs of study (dental and pharmacy). The Optometry Council Australia and New Zealand noted in its submission to the Discussion Paper that it includes community representatives on accreditation committees. The Council on Chiropractic Education Australia advised that it includes consumer representatives (patients, carers or community members) on assessment panels for education programs or providers, and the Australian Dental Council in its submission to the Discussion Paper advised that *“All consultations for reviews of standards have involved a direct request for input by consumer groups including the Consumer Health Forum”*. (DP p24)

Accreditation authorities can also require education providers to demonstrate consumer (service user) involvement in the design and development of programs of study. The Occupational Therapy Council (Australia and New Zealand) advised in its submission to the Discussion Paper *“Current standards require evidence of consumer input into curriculum and learning activities – consumers in education provider advisory panels as well as in teaching and assessment roles”*. (DP p6)

Education regulators such as TEQSA use external experts to provide advice on regulatory issues and to participate in regulatory assessment processes. TEQSA has a [Register of Experts](#) who are expected to have and maintain significant experience in areas relevant to its scope of work. It is understood that the Register is targeted towards persons with education and training expertise and with significant experience in the governance of educational institutions.

As noted earlier, the Higher Education Standards Framework (Threshold Standards) 2015 has a requirement for student feedback as part of overall assessment of institutional quality assurance. The TEQSA assessment processes are also linked with other opportunities that enable [student](#) and employer input. For example, all Australian universities and many other higher education providers use the [Quality Indicators for Learning and Teaching](#) to obtain feedback from students, graduates and employers regarding program quality.

While recognising the many initiatives already being undertaken, the Review urges all stakeholders to actively involve consumers in the following functions:

- in the development of accreditation and competency standards
- in the design of education and training programs, including curricula
- in the assessment of programs of study and education providers as appropriate.

The Review supports AHPRA’s initiative in establishing its Community Reference Group but notes that its seen by some as having limitations. Consumer representatives at the workshop organised by the Consumers Health Forum of Australia for this Review advised that issues brought to the Community Reference Group were determined by AHPRA and there was limited feedback from AHPRA and National Boards on how their feedback was treated. These matters should be addressed by AHPRA.

The Review considers that the terms of reference of the Reference Group should be expanded to include a consumer perspective on accreditation. As the group is already approached for advice regarding other health workforce issues, it can provide a useful perspective on the effectiveness of the National Scheme as a whole, including the extent to which the different professions are operating cohesively to achieve team-based patient-centred care.

## Recommendations

7. Accreditation standards should include a consistent requirement that education providers demonstrate the involvement of consumers in the design of education and training programs, as well as demonstrate that the curricula promote patient-centred health care.
8. AHPRA should expand the Terms of Reference for the AHPRA Community Reference Group to include accreditation functions and enable accreditation authorities to refer issues to the Group for advice.

## Outcome-focused accreditation standards

Historically, higher education has focused on subject and time-based learning with summative assessment. This emphasised knowledge rather than the attainment of competency. A competency-based approach focuses on monitoring performance and establishes measurable metrics that demonstrate successful achievement of competencies ([Gruppen](#), 2012). As noted by Garfalo *“Competency based education moved education from an academic focus (what graduates need to know from an academician’s point of view) to a workplace focus (what graduates need to know and do in a variety of complex workplace situations)”*. (2016, p97)

The Health Professions Accreditation Collaborative Forum (HPACF) has adopted or produced a number of documents that provide guidance to accreditation authorities in the delivery of best practice accreditation. For example, the [High Level Accreditation Principles](#) (2016) recommends:

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

An outcome-based approach, with an emphasis on competence, provides flexibility to respond to changes in community needs, technology and innovations in health practices. It puts the onus on education providers to demonstrate that the program of study and associated training (however delivered) will produce high-quality graduates with the knowledge, skills and professional attributes necessary to practise the profession.

Most accreditation authorities are either considering, developing, or have already implemented accreditation standards with a focus on outcomes. Some examples include:

- **Medicine:** [Procedures for Assessment and Accreditation of Medical Schools](#) (2017) notes that assessments focus 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) recognises 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) outlines the attributes and competencies required. Providers need to demonstrate that learning outcomes from the curriculum address the competencies and the relationship between learning outcomes and the assessment method.

Whilst recognising the need for outcome measures, some stakeholders expressed support for some retention of input based standards as providing clear guidance to education providers and directing the minimum achievement of specific tasks. As noted by James Cook University: *“...care should be taken when describing outcome measures, as many qualities defined as such are often more appropriately described as outputs. In some instances, there will remain a need to describe inputs with a clear relation to outputs and outcomes”*. (DR p3)

Many of the input requirements identified in existing accreditation standards relate to hours of workplace experience. Interaction with patients is essential for the development of professional skills such as communication and empathy ([Leonard](#), 2004) and workplace experience is a key component of any program of study to develop these competencies. While it is intuitive that more hours of practice or the more times a task is completed will lead to more highly developed skills (as implied by the “Minimum Operative Experience” required by some specialist medical colleges), validated measurement and a holistic assessment of competence should align with the attainment of learning outcomes. It is also noted that specifying a number of hours does not assure quality. As reported by Australian Catholic University:

*“While students value exposure to the workplace during their courses, there is little evidence to support a fixed number of hours of supervised practice for any health discipline. The crucial element is the overall outcome of the learning experience that occurs within a course of study rather than the input measure that is the proxy for this outcome”*. (DR p5)

Another reason for including hours of workplace experience in accreditation standards was attributed to the specifications of international professional associations. Alignment can provide overseas mobility for practitioners, and participation in international forums is supported, but is not a sufficient reason to maintain an input-based accreditation standard at the risk of limiting the flexibility and responsiveness of curricula.

Many submissions to the Discussion Paper proposed a balance between input and outcome-based standards.

Box 5.2. Input-based versus outcome-based standards

**Australian Medical Council**

*The AMC supports outcome based standards; these are better correlated with medical practitioner skill sets and, ultimately, health outcomes. It is also important to consider inputs when undertaking accreditation, as this facilitates analysis and discussion of the causes of variation in outcomes. What is not warranted or necessary, in the AMC's experience are standards that prescribe particular governance structures, processes, a particular curriculum model, or specific hours or subjects. (DP p14)*

**Australian Psychology Accreditation Council**

*Our focus in our proposed new standards has moved from an inputs-based approach to primarily an outcomes-based approach, albeit supported by a number of key inputs which have been retained at the request of stakeholders. We expect that this change will allow for more flexibility in the ways providers may choose to structure programs, and allow for innovative and effective approaches to learning and teaching. (DP p16-17)*

**Australian Rural Health Education Network**

*The outcomes based accreditation framework should focus education providers on determining and demonstrating how they meet accreditation and curriculum specifications, including the depth, complexity and volume of learning, rather than simply ticking boxes associated with inputs and outputs. (DP p4)*

**Division of Tropical Health and Medicine, James Cook University**

*Overall, there needs to be a balanced mix of input, process and outcome-based standards. We also recommend that all accrediting teams consider performance measures such as QILT and other higher education innovations in the Australian scene in their assessments. We also emphasise a need for the criteria for the outcome-based standards to be clearly defined. (DP p16)*

**Australian Catholic University**

*There may be circumstances where input and process standards are required but, in most cases, input standards are unjustified. For instance, the hours some disciplines prescribe for clinical learning are not justified by research and are quite arbitrary, and do not allow simulation to be a recognised adjunct to clinical supervision. (DP p5)*

**Curtin University**

*Standards driven by evidence and practice. Currently there is no transparency on the fundamental drivers that create the standards. For example, is there any evidence that a staff ratio of 1:15 is necessary for effective small group work, or that a minimum of 600 hours vs 1000 hours of supervised clinical practice is necessary to graduate a competent practitioner? (DP p1)*

**Faculty of Pharmacy, University of Sydney**

*We are of the view that input and process standards should be included, where warranted. Educationally speaking, this issue and #9 below, speak to a broader and important point about assessment, outcomes and standards. All three should be closely aligned, particularly as some risks to the sustainability and quality of the programs are input-related, for example, governance, finances, staffing profile in terms of qualification and expertise, quality and numbers of the student cohort. (DP p3)*

**Director from a University Department of Rural Health, Australian Rural Health Education Network**

*An inputs/outputs approach can be a real problem in rural and remote placements. We may have a student on placement working with patients with very complex needs but because scheduled patients don't show due to the vagaries of travel or whatever, they can't tick off the nominal number of required consultations. This approach gives no weight to the fact that the patients they have seen have multiple issues and complex needs providing a much richer and challenging learning experience that has in fact ticked off all the learning requirements. (DP p4)*

Assessment against outcome-based standards can be more complex than measurement against defined inputs. In this context, Holmboe (2010) suggests that competency-based education requires a multi-pronged approach that includes summative and clinical skills assessment, but with a greater focus on formative assessment to ensure a student receives frequent and high-quality feedback that assists in their ongoing development of competencies.

A number of submissions to the Draft Report also highlighted that assessment of true outcome measures may not be possible during a program of study where indicators of outcomes are not well established or if they apply to longer-term skill development where the demonstration of the skill is more likely once in the work place. This is outside the realm of an education provider's accountability.

The move to competency-based approaches in professional accreditation is largely supported by stakeholders. However, it is evident from submissions that input and process based indicators can, in certain circumstances, add value to the assurance of quality and contribute to demonstrating that an accreditation standard domain or element has been achieved. It was suggested that without these indicators types the '*cheapest option may become the priority driver*' (Australian Council of Deans of Health Science, DR p5) thus potentially compromising the quality of the program or limiting opportunities for clinical experiences. A balance must be achieved between including them for directive guidance and ensuring delivery of the desired outcomes of safe and competent graduates.

To ensure relevance and consistency across professions, it is proposed that elements within accreditation standards must be measurable, purposeful, underpinned by strong evidence, supported by wide-ranging consultation and peer review and be consistent with achieving the National Law objectives.

### Recommendation

9. Accreditation authorities should focus on outcome-based approaches when developing new, or revising existing, accreditation standards. Where input or process based indicators are deemed necessary, they should be justifiable, non-restrictive and consistent with achieving the National Law objectives.

## Health profession competency standards

The competence of health practitioners underpins the integrity of the registration system, and professional entry education and training is expected to deliver the required knowledge, skills and professional attributes necessary to practise the profession. The joint National Boards/AHPRA submission notes the importance of professional capabilities:

*"professional capabilities have a critical regulatory purpose because they establish threshold capabilities for initial (and continuing) registration. Because the focus is on registrant capability, they should reflect contemporary practice and provide an important mechanism to respond to changing consumer and health service needs and priorities". (DP p7)*

Each health profession accreditation standard refers to professional competency standards (also known as professional capabilities, professional attributes, standards or thresholds for practice). These standards describe the desired characteristics and threshold competencies of graduates and entry-level practitioners, with some specifying the attributes that apply throughout the career continuum of the practitioner. They underpin the curricula developed by education providers and are used by accreditation authorities in their assessment processes. As depicted in the [Chiropractic Accreditation and Competency Standards](#) (2017, p4), accreditation standards and competency standards are inextricably linked.





Figure 5.1. Relationship between accreditation and competency standards

## Development of competency standards

The authorship and ownership of the competency standards is variable across professions. The National Boards, accreditation councils and professional associations can all have roles. Competency standards are not developed formally within the purview of the National Law, even though they are referred to in the accreditation standards.

The joint National Boards/AHPRA submission (DP p7) notes that “*since the National Scheme, the direction is increasingly for National Boards to fund development and ‘own’ the capabilities*”. This may also reflect the move of some competency standards towards a [CanMEDS](#) approach, which applies to practitioners across the career continuum and demonstrates the potential relevance to other aspects of practitioner regulation such as continuing professional development (CPD).

The involvement of educators, practitioners, professional associations and regulatory bodies in the development and review process is identified in many existing competency standards. However, few standards mention the involvement of consumers and others (for example, employers or target population groups such as Aboriginal and Torres Strait Islander peoples) who could provide critical perspectives of community need and broader workforce reform. As noted by the Australian Healthcare and Hospitals Association:

*“Such frameworks should be developed in collaboration with employers and education providers (so there is agreement in expectations for ‘work readiness’ and the delineation between registration requirements and employer training are clear), and with consultation with the public and Governments (so that public expectations are met, safety can be assured and health workforce reform can be achieved). If there are multiple steps towards becoming registered, the framework should identify the expectations of students at each step, reflecting a clear continuation towards being competent”.* (DP p6)

The Australian Medical Council (AMC) observed:

*“the AMC considers that health consumers, employers, jurisdictions, education providers and other health professions as well as the medical profession have capacity to contribute to the development of these competency frameworks”.* (DP p15)

Given the strong relationship between competency standards and how a practitioner works with their patients and functions in the work environment, it is important that they appropriately reflect contemporary practice. As such, the principle of the “*wide-ranging consultation requirements*” for accreditation standards, outlined in the National Law (s46(2)), should equally apply to the development of competency standards.

The Review considers that the development and approval of competency standards is integral to the National Scheme. It would be consistent with the National Registration Boards’ focus on individual practitioners that the responsibility for these standards rests with them in a more formal manner. To ensure broad consultation, and



that these competency standards adequately provide the foundation for educating the future health workforce, their development and final approval should be in accordance with the legislative provisions established for the development of registration standards by National Boards and their approval by Ministerial Council under the National Law.

## Content and structure

Rather than specifying the detail of any curriculum, competency standards provide guidance to education providers on the required learning outcomes for a program of study. During an accreditation assessment, evidence demonstrating that the curriculum is mapped against the domains, elements and performance criteria of competency standards is examined to assure graduates will achieve the required learning outcomes.

While technical skills and knowledge define a particular profession, there are common competencies across all health practitioners that contribute to healthcare practices. A number of projects and frameworks have sought to define these underpinning common competencies, as demonstrated by two initiatives outlined below.

### *Threshold Learning Outcomes for Health, Medicine and Veterinary Science*

In 2011, as part of a broader higher education reform agenda, the Australian Learning and Teaching Council developed the [Threshold Learning Outcomes](#) (TLOs) for Health, Medicine and Veterinary Science to align with the Australian Government's standards-based quality assurance framework. The TLOs were developed to provide an overarching statement of healthcare professional-entry level outcomes and to define common domains of competence that graduates are expected to demonstrate. The TLO domains are:

- Demonstrate professional behaviours
- Assess individual and/or population health status and, where necessary, formulate, implement and monitor management plans in consultation with patients/clients/carers/animal owners/communities
- Promote and optimise the health and welfare of individuals and/or populations
- Retrieve, critically evaluate, and apply evidence in the performance of health-related activities
- Deliver safe and effective collaborative healthcare
- Reflect on current skills, knowledge and attitudes, and plan ongoing personal and professional development.

During development, the TLOs were mapped against existing professional competency standards to identify alignment and logical fit. Further to this, in 2014, the [Harmonisation project](#) 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". (p5)*

The project sought to create common assessment principles that, through achievement of the TLOs, would demonstrate compliance with accreditation, registration and higher education quality assurance requirements. This would potentially minimise the burden and cost of accreditation processes. The project outcomes included engagement between disciplines, with the production of a framework of principles for incorporating professional accreditation and Australian Qualifications Framework (AQF) standards into assessment mapping in health disciplines. While the TLOs are mentioned in some accreditation reference material, there does not appear to be an approach to further their adoption or to standardisation.

### *Common Health Capability Resource*

Health Workforce Australia (HWA) developed a '[Common Health Capability Resource](#): shared activities and behaviours in the Australian health workforce', which identifies five "*overarching domains of activity common to the Australian health workforce*" (p9) as depicted in figure 5.2.

The capability resource is a tool to inform workforce innovation and reform initiatives and support the development of common behavioural attributes in the workforce. While it extends beyond the learning outcomes expected of a professional-entry program of study, the similarities with the TLOs are evident. Competency standards for at least ten registered and five self-regulating professions were used in developing the capability resources; however, it is not mentioned in current competency standards, and its current use is unknown.

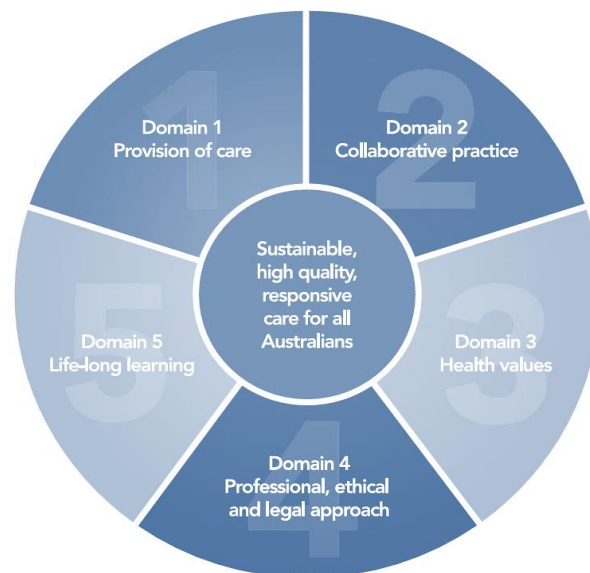


Figure 5.2. National Common Health Capability Resource: five domains

Consistent with the findings of the TLOs and the HWA common capability initiative, the Review’s analysis of current health professional competency standards highlights a range of common qualities, abilities, skills and required knowledge expected from safe, high-quality health practitioners. These attributes include communication, professionalism and ethical behaviours, patient assessment and care, leadership, collaboration, cultural competence, critical thinking and evaluation, population health and comprehensive care. As noted by the ACSQHC:

*“The Commission supports the view that there is a common set of qualities, abilities, skills and required knowledge expected from high-quality health practitioners, including key competencies related to safety and quality and cultural safety and awareness. This common set of requirements for effective practice in the Australian health care delivery system underpins the competencies that are specific to different professions and specialties”.* (DR p7)

Despite this, each framework uses different structures, terminology and domains (or fields or elements) that define a competent health practitioner. For example:

- **Physiotherapy:** [Physiotherapy practice thresholds in Australia and Aotearoa New Zealand](#) (2015) describes the “competence required for initial and continuing registration” and outlines 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.
- **Osteopathy:** [Capabilities for Osteopathic Practice](#) (2009) describes six domains: 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) describes four domains that define a competent medical graduate: 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.

At least two professions use a format that categorises the domains of competence into roles of the practitioner. This is similar to the CanMEDS framework developed by the Royal College of Physicians and Surgeons of Canada, which extends the relevance of the framework beyond professional-entry to the skills demonstrated across the career continuum.

Submissions to the Discussion Paper provided a range of views on standardisation of competency standards, particularly highlighting the importance of maintaining a profession's value and individuality.

#### Box 5.3 Greater commonality across competency standards

##### **Council of Ambulance Authorities**

*A set of common competencies could be developed similar to those used by the UK HCPC and used to complement profession specific competencies, as well as providing a higher level of consistency across registered professions. The intra-disciplinary opportunity arising from the common competencies arrangement would be valuable especially in rural and remote settings where training opportunities can be infrequent. (DP p5)*

##### **Australian Physiotherapy Council**

*...the Thresholds in Australia and Aotearoa New Zealand (2015) describe the competence required for initial and ongoing registration and describe the varying roles played by a physiotherapy practitioner. The Council notes that these roles share similar themes or domains with other available health professional frameworks, largely based on the CanMEDS framework and agrees that there would be value in working toward shared professional competency frameworks. Shared frameworks may have the additional benefit in providing a platform for reinforcing and embedding interprofessional learning. A useful starting point may be to agree on consistent and shared terminology with the other health professions. (DP p8)*

##### **Joint National Boards/AHPRA**

*There is also potential to achieve increased commonality across accreditation standards and potentially professional capabilities, on areas relevant to all professions to complement profession-specific content. Joint work by some Accreditation Authorities on interprofessional education and the Health Professions Accreditation Collaborative Forum work on prescribing are examples which could be built on to progress work on other important areas such as Aboriginal and Torres Strait Islander health and cultural competence. (DP p7-8)*

##### **Australian Physiotherapy Association**

*We believe a common approach to the development of professional competency frameworks would reduce the standards of safety and quality within the physiotherapy profession, and would endanger the public. We support a consistent approach to the accreditation of common elements of health programs; however common requirements should not be extended to professional competency frameworks. ...So while it may be tempting to look for a common approach to the formulation of profession specific competency frameworks, we believe that this would stifle the development of contemporary professional frameworks and limit the schemes ability to take a global approach to professional competency frameworks. (DP p10)*

##### **Australian Medical Council**

*The AMC competency framework is a set of graduate outcome statements, based on four domains which describe the roles of the medical practitioner. The AMC chose this structure because it is commonly used in most medical schools. There is no intrinsic benefit in aligning graduate outcomes for medicine with another profession. They are separate professions with separate roles. There is, however, benefit in aligning medical school and intern outcomes which the AMC has done. (DP p15)*

The Review agrees with the various submissions that pointed out the paramountcy of professional input in the development of competency standards and in assessment processes to ensure the underpinning performance criteria and indicators are interpreted in the context of the profession in practice and reflect the specific capability requirements. Nonetheless, there are also cross-professional abilities, skills and required knowledge requirements in competency standards. This argues for a more standardised approach to their terminology and structure, and identification of a common set of requirements for effective practice that emphasise collaborative practice and team-based care.

## Safety and quality standards, including cultural safety

National guidelines and system-wide safety and quality standards for health and social care, and its workforce, are regularly updated to reflect evolving community needs. These documents outline a national policy direction and provide guidance to the health system on the processes and procedures required to deliver safe, high-quality and culturally respectful services. Given their application to workforce behaviours, it is reasonable to expect that they are reflected within an education provider's program of study to ensure health graduates have the most current knowledge, skills and professional attributes required to practise the profession. The relevant elements could either be referenced within competency standards or as content and context within a health curriculum as demonstrated by the examples provided below.

### *National Safety and Quality Health Services Standards*

ACSQHC is the government agency responsible for driving a sustainable, safe and high-quality health system. ACSQHC develops the National Safety and Quality Health Service (NSQHS) Standards and oversees the accreditation of health service settings through the approval of accrediting agencies to assess health service organisations against these standards. While the NSQHS Standards are directed at organisational clinical governance, health practitioners employed in these health services are responsible for providing care in accordance with these standards.

*“The Commission recognises that, in order for health services to meet the requirements of the NSQHS Standards, their health workforce must have the necessary skills and competencies. ... The capacity of health services to meet the NSQHS Standards depends on the knowledge, skills and actions of their clinical staff”. (DR p7)*

The [NSQHS Standards](#) (second edition) were approved by Ministers in June 2017. They comprise eight standards including clinical governance, partnering with consumers, preventing and controlling healthcare-associated infection, medication safety, comprehensive care, communicating for safety, blood management and recognising and responding to acute deterioration. Many are central to the clinical practice of health practitioners and should be reflected as professional competence or incorporated into a program of study. This includes the tenet of ‘comprehensive care’ to ensure patients receive coordinated health care that aligns with their goals and is managed by a collaborative health care team. Interprofessional practice is identified as a key component of future health care delivery and is discussed further below.

ACSQHC has completed a number of projects with professions and education providers to understand the inclusion of NSQHS Standards in curricula. Recently, they surveyed education providers to determine what they currently teach about the NSQHS Standards and to examine alignment with the programs of study for a number of health professions. While analysis is ongoing, the ACSQHC reports:

*“This work has been challenging, given the number of relevant regulatory bodies for health professional education, ... the most recent survey reinforces previous work that suggested gaps in the coverage of safety and quality issues relevant to the NSQHS Standards and finds that delivery of information on the topics and skills that relate to the NSQHS Standards appears to vary considerably across different disciplines”. (DR p8)*

The outcomes of this project will inform the development of supporting materials for implementation of the NSQHS Standards and could also guide references in professional competency standards.

### *Aboriginal and Torres Strait Islander health – cultural safety and capability*

Given the priority to address generally poorer health outcomes for Aboriginal and Torres Strait Islander people, it is important to ensure all health practitioners are equipped with cultural capability. As noted by CATSINaM “...cultural safety and respectful practice are as important to quality care as clinical safety”. (DP p5)

In 2011, HWA released ‘[Growing Our Future](#): Final Report of the Aboriginal and Torres Strait Islander Health Worker’ project, which sought to strengthen the Aboriginal and Torres Strait Islander health workforce. It also identified the need for non-indigenous health professionals to be clinically and culturally capable and recommended embedding cultural competency curricula in all health professional training. In response, the [Aboriginal and Torres Strait Islander Health Curriculum Framework](#) (2014) was developed to provide a benchmark for cultural capability standards and an interprofessional approach for consistent learning outcomes. This document provides resources and guidelines, including for accreditation authorities, for incorporating cultural capability within programs of study.

As noted by Edith Cowan University:

*“This has seen some excellent developments in the implementation of Aboriginal and Torres Strait Islander health curricula across some professional organisations and accreditation authorities, though more can be done by other accreditation authorities, particularly those sitting under the NRAS, to adopt this Curriculum Framework”. (DR p13)*

In 2016, the National Aboriginal and Torres Strait Islander Health Standing Committee developed the [‘Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health’](#) for AHMAC. The framework commits all governments to include *“cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services”*. The vision of this framework is to provide better and more culturally aware health care.

In addition, the National Boards, AHPRA and accreditation authorities and partner indigenous organisations have established an Aboriginal and Torres Strait Islander Health Strategy Group to develop an ‘Aboriginal and Torres Strait Islander Health Strategy for the National Registration and Accreditation Scheme’. The vision of this [strategy](#) is to achieve the following outcome:

*“Patient safety for Aboriginal and Torres Strait Islander peoples in Australia’s health system is the norm, as defined by Aboriginal and Torres Strait Islander peoples”*.

The 16 June 2017 [Communiqué](#) affirms the importance of cultural safety and Aboriginal and Torres Strait Islander health training for all practitioners under the National Scheme. Future work includes exploration and interrogation of existing baseline data, development of clear measurable objectives to monitor implementation and performance of the strategy, approaches to supporting representation of Aboriginal and Torres Strait Islander people on National Boards and opportunities to develop cultural safety capability within the National Scheme. The Communiqué also outlines the plan for the Aboriginal and Torres Strait Islander Health Strategy Group to develop a clear statement of intent for the Scheme that reflects the vision for all National Scheme bodies and Indigenous partner organisations to consider and endorse.

Many accreditation standards already specify the need for cultural competence to be integrated into programs of study. Applying equally to all health professions, the Australian Indigenous Doctor’s Association noted:

*“Formalising an expectation of cultural safety in standards for accreditation would ensure that trainees and fellows, both Indigenous and non-Indigenous, and medical college staff are culturally safe and provide optimal education and employment environments for Aboriginal and Torres Strait Islander people”*. (DP p3)

Safe and high-quality health care, and cultural safety and awareness, are key competencies for all practitioners and should be included within competency standards. Consistent and mandated references, in both accreditation and competency standards, would ensure implementation in all health practitioner education and training programs.

It is recognised that identifying a particular topic for inclusion within an accreditation standard or competency standard is often not enough to ensure active implementation within a program of study – as demonstrated with the extensive and ongoing program of work for implementation of interprofessional education and practice. The Australian College of Rural and Remote Medicine reflected that:

*“It should be noted that the NRAS is not the only mechanism by which healthcare priorities can or should be incorporated into professional education. Valuable initiatives also arise out of direct dialogue between the government (jurisdictional and federal) and colleges/professional organisations as appropriate to address specific health priority issues”*. (DP p6)

Guidance and clear direction is required to ensure a consistent approach to competency standards, including the determination of the common competencies across health professions and their inclusion as a core element within accreditation standards. This will create a pathway for implementation within programs of study, clinical placements and in the workplace. It will also contribute to system-wide efficiencies and effectiveness through a common agreement on the competencies required for high quality and culturally safe patient care.

## Recommendation

10. National Boards should develop, and recommend to the Australia’s Health Workforce Ministerial Council, profession-specific competency standards formally under the National Law in accordance with the legislative provisions established for the development of registration standards. Competency standards should be developed cooperatively through wide-ranging consultation to achieve:
- a. standardised definitions and terminology
  - b. agreement on those competencies that are common to all health professions and profession-specific performance criteria and indicators
  - c. inclusion of specific and consistent references to:
    - i. NSQHS Standards for quality and safety, including collaborative practice and team-based care, developed in partnership with the Australian Commission on Safety and Quality in Health Care
    - ii. cultural safety and Aboriginal and Torres Strait Islander health developed in partnership with the National Scheme’s Aboriginal and Torres Strait Islander Health Strategy Group
  - d. alignment with service models and responsiveness to national health workforce priorities that best serve evolving community health care needs.

## Interprofessional education, learning and practice

Interprofessional practice is an important contributor to positive health outcomes through improved communication, efficiency, cost effectiveness and the patient-centeredness of the health care team (McNair, 2005).

The Centre for the Advancement of Interprofessional Education, in its [Interprofessional Education Guidelines 2017](#), defines interprofessional education (IPE) as “occasions when two or more professions learn with, from and about each other to improve collaboration and quality of care”. The World Health Organization’s (WHO) [Framework for Action](#) on Interprofessional Education and Collaborative Practice (2010 p7) notes that IPE is a “...necessary step in preparing a ‘collaborative practice-ready’ health workforce that is better prepared to respond to local health needs”. This Framework adds the objective of improving health outcomes to the definition of IPE which recognises the importance of team-based health care in the delivery of safe and high-quality patient-centred health services.

As noted in the WHO’s 2010 Framework, IPE must be purposeful. It requires supportive management practices, a resolve to change the culture and attitudes of professional bodies and workers, and a willingness to update and renew existing curricula. It must extend beyond the classroom where different professions learn common subjects, to pursue opportunities for shared communication, understanding roles and functions of other health professions, and collaborative and innovative team-based practice models with patients at the centre of care. Educators and supervisors must be trained and supported to deliver and assess well-constructed learning outcomes ([Stein](#), 2016) – irrespective of profession or discipline.

The accreditation system plays an important role in ensuring the quality and integrity of education and training and has the capacity to influence the scope and implementation of IPE initiatives. As observed in the ‘Securing an Interprofessional Future’ (SIF) submission to the Discussion Paper:

*“Accreditation not only acts as a cultural marker of inclusion, legitimacy and status but, importantly, in terms of available incentives, requires action that meets externally prescribed criteria”.* (DP p8)

HPACF members adopted a statement about the principles of interprofessional learning and associated competencies at the Forum’s Interprofessional Education Workshop in 2015. The [position statement](#) notes the HPACF supports innovation in education and training and endorses a shared definition and commitment to support good practice.



As a consequence, all accreditation standards reference interprofessional learning and practice as an element of health professional programs of study, albeit with different terminology and requirements. For example:

- **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 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.

IPE has been on the national agenda for almost a decade, with projects funded by Commonwealth and state entities. Since 2009, the Commonwealth Government has supported work to promote and develop IPE (as outlined in the 2016 'Curriculum Renewal in Interprofessional Education in Health: [Establishing Leadership and Capacity](#)' report). This included the identification of eight [Interprofessional learning competency standards](#) as part of the Harmonisation extension project. Current work includes the project '[Securing an interprofessional future for Australian health professional education and practice](#)'. The intended outcome is a whole-of-system approach to Australian IPE "to ensure that every student who graduates from an Australian university with a health profession qualification at entry level has achieved the core capabilities required for successful interprofessional and collaborative practice and continuing interprofessional learning". (DP p3)

Like many other countries, Australia has numerous examples of successful IPE and collaborative practice. However, the sustainability of these pockets of proactive and positive initiatives is often precarious as they tend to be local, organisation-based and/or dependent upon change champions. The literature highlights that IPE opportunities can be difficult to execute in health programs due to issues such as entrenched professional and organisational cultures, limited financial resources, conflicting curricula, and supervision of clinical placements (Lawlis, 2014). Similar issues are reflected in the WHO's [Interprofessional Collaborative Practice in Primary Health Care: Nursing and Midwifery Perspectives. Six Case Studies](#) (2013).

While IPE is acknowledged in the accreditation standards, and accreditation authorities have a common agreed definition, IPE is still not consistently represented in education curricula or course delivery and a clear understanding of its implementation in practice and measures of success have not been established. Several submissions to the Draft Report raised concern about the differing approaches, understandings and configurations of interprofessional practice. However, it is noted that there are few examples of countries that have managed to successfully incorporate IPE into their accreditation process, although Canada and the United Kingdom are working towards this objective (SIF project, DP p6).

Incentives and drivers are required to systematically put this concept into practice, such as through the development of common, practical and overarching guidelines for IPE implementation and accreditation assessment. A number of submissions identified the role of the accreditation system in creating a collective and shared approach.

Box 5.4. The role of the Accreditation system in IPE

#### **Australian Dental Council**

*If the vision remains narrow or there is an unwillingness to engage in these discussions regarding the future health needs and health workforce needs, interprofessional education or other initiatives will fail before they begin simply because they have no purpose. (DP p14)*

#### **Securing an interprofessional future for Australian health professional education and practice project**

*While it may well be that additional powers and incentives are required by the Australian accreditation system, there is both a need for and an opportunity to prescribe greater consistency and commonality in the way in which IPE standards are defined and IPE accreditation conducted. (DP p9)*

#### **Australian Psychology Accreditation Council**

*A criterion in the standards, common to all professions, requiring inter-professional education to be part of all programs of study, would be acceptable to APAC. (DP p19)*



Box 5.4. The role of the Accreditation system in IPE

#### **Australian Osteopathy Accreditation Council**

*Further development of inter-professional education (IPE) across the professions would require a shared standard with a clear definition for the term IPE together with criteria to ensure consistency. The standard needs to be sufficiently broad to enable innovative approaches by education providers to meet the standard while taking account of the structural constraints education providers face in delivering interprofessional learning. (DP p9)*

#### **Medical Deans Australia and New Zealand**

*It is important the focus remains on the intended outcome which is the delivery of effective team based health care, not the delivery of an interprofessional educational activity. Not all interprofessional educational activities result in better team-based care; some detract from it.*

*There are some common curricular domains (e.g. professionalism, leadership, communication, research skills) across many health professional degree courses and a common approach in these areas may be achievable. However, interprofessional learning opportunities need to be real and not contrived and can be extremely resource intensive to deliver. (DP p5-6)*

#### **University of Newcastle**

*...good inter-professional practice is not commonly seen in the workplace so translating education to practice is difficult and the priority of IPE in curricula and for students is diminished. (DP p5)*

#### **Joint National Boards/AHPRA**

*The National Scheme can make an important contribution to embedding interprofessional education and practice in the health system but cannot achieve this alone. Including IPL in entry to practice education is only one part of what is needed to effectively promote and build interdisciplinary practice. (DP p9)*

#### **University of Sydney**

*The University supports evidence-based reform of accreditation processes that aim to more closely align those processes to education and research strategies of relevance across the range of health professions, such as in interprofessional education and in translational science. We see two primary benefits.*

*The first is that graduates' mastery of common health profession elements and domains provides an enriched understanding of the broader systems within which graduates operate, as well as a strong foundation for interprofessional communication and innovation.*

*The second is that interprofessional health care is known to enhance patient care outcomes. Interprofessional learning as an important component of clinical training supports multi-professional input for more complex assessment and diagnostic presentations, training and clinical practice needs. If the intent of accreditation processes were more aligned to evaluate contemporary health professional education strategies, those accreditation processes could directly contribute to the achieving of strong educational objectives. (DP p7)*

It was also suggested to the Review that 'team-based care' should be seen as the outcome of interprofessional practice opportunities, and a common approach in the enforcement of the accreditation standards should reflect this goal to ensure a workplace focus. As noted by MDANZ *"It is important the focus remains on the intended outcome which is the delivery of effective team based health care, not the delivery of an inter professional educational activity"*. (DR p5) The Review acknowledges that the greater objective of team based care delivery is more closely linked with the design of institutional work arrangements and with incentives that drive the behaviour of individual practitioners than it is with students partaking in IPE, but the pursuit of such reforms is outside its scope.

Nonetheless, even within the narrower scope of this Review, there is sufficient robust evidence and cross-sector support for the inclusion of a standardised approach to IPE within accreditation standards that reflects an agreed definition and focuses on the achievement of learning outcomes related to patient-centred, comprehensive care. The Review considers that interprofessional practice needs equal recognition in competency standards and that quality interprofessional practice, as facilitated by IPE, should also be reflected in CPD requirements to place a greater emphasis on the use and uptake of team-based care in the workplace.

It is evident from the slow progress to date that a more authoritative cross-professional governance system is required to drive this agenda and provide a feedback loop between workforce priorities, programs of study and accreditation assessment. Such an approach could provide guidance on IPE opportunities, assessment processes and the evidence required of education providers to demonstrate achievement of this element. Ultimately, a consistent approach may allow adoption of assessment findings across professions (to eliminate the need for multiple ‘siloed’ assessments) and evaluation of IPE across a health school or faculty.

It is noted that the ‘Securing an interprofessional future’ project is seeking to establish an IPE council to “enable and support the formulation, design and uptake of common IPE standards and a common approach to accreditation and develop resources to support implementation in higher education and in practice settings”. (DP p12) As noted in Chapter 7, an integrated approach to accreditation governance could support the delivery of this project.

### Recommendation

11. Accreditation authorities in their development of accreditation standards, and National Boards in their development of competency standards, should use agreed definitions for interprofessional learning and practice. This should be supported by guidance material, developed through broad consultation, which clarifies expectations of education providers and outlines a competency-based assessment approach that focuses on facilitating team-based practice and collaborative care.

## Clinical experience and student placements

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

As health care evolves towards more patient-centred, integrated services, there is a need to ensure that clinical placement opportunities adequately reflect future community need (Stein, 2016). Recognising that some professions are more likely to work in particular settings, clinical placements should reflect the context of those future workforce practices. This may include flexible and creative placements in primary care as well as in ‘expanded’ and non-traditional settings, such as in rural and regional areas, and with specific demographic groups, such as disadvantaged communities, to ensure students are adequately prepared to deliver safe, high-quality services in a range of environments.

Education providers have a responsibility to proactively facilitate health care reform and the accreditation system should assist in promoting and facilitating ongoing leadership and innovation. As noted by [Frenk](#) (2010):

*“the challenges for academic systems is to provide a more balanced environment for the education of professionals through engagement with local communities, to proactively address population-based prevention, anticipate future health threats and to lead in the overall design and management of the health system”.* (p1940)

This reflects a key objective of the National Law “to facilitate access to services provided by health practitioners in accordance with the public interest”. The Commonwealth Government’s [Health Care Homes](#) initiative will also require education providers and regulators to ensure that their training adequately prepares 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 required practitioner competencies. The HPACF, in its [Essential Elements of Education and Training in the Registered Health Professions](#) (2015), identifies that accreditation standards should specify a number requirements for clinical education and training in health programs including “use of an appropriate variety of clinical settings, patients and clinical problems for training purposes”. (p13) A number of standards reflect this direction, for example:

- **Nursing:** Standard 8 of the [Registered Nurse Accreditation Standards](#) (2012) states that each student should be 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.
- **Occupational Therapy:** Section 4 Practice Education/Fieldwork of the [Accreditation Standards for Entry-Level Occupational Therapy Education Programs](#) (2013) notes that fieldwork experiences will also encompass different delivery systems such as hospital and community, public and private, health and educational, urban and rural, and local and international.

Some submissions identified both opportunities and barriers to delivering more responsive clinical placements.

#### Box 5.5. Clinical placements to reflect future health service

##### Faculty of Pharmacy, University of Sydney

*If flexibility and responsiveness are the desired qualities of an education program, then the focus should be on creating practitioners who are able to change with the evolving context – which includes evolving health care priorities. This suggests skills development priority as part of the education experience. (DP p4)*

##### Department of Health Northern Territory

*Healthcare priorities will vary across jurisdictions. NT education providers understand local requirements/environments such as the challenges of working in remote locations. Interstate education providers also need to understand the NT context as many students in the NT are from interstate, particularly in nursing, and many do placements in the NT especially for allied health, where courses are not taught in the NT. Student exchanges may help develop the experience and skills of students for remote practice. (DP p7)*

##### Division of Tropical Health and Medicine, James Cook University

*Accreditation requirements often restrict DTHM's capacity to administer clinical placements in strategic locations, including in areas relevant to students' future practice where there is high health workforce need. Highly prescriptive requirements about the experience of clinical supervisors, types of settings and quality of facilities in some specific disciplines limit the University's ability to offer students 'accredited' professional experience placements, particularly in rural, remote and international settings. The barriers relate to limited provision for inter-professional supervision, including strict 'who, what, where' guidelines. (DP p12)*

##### Occupational Therapy Australia

*Occupational therapy is a profession particularly affected by issues with sourcing practice placements, ..., and any support and encouragement that can be offered to institutions, educators and the profession, to think laterally and "outside the box" on this issue, and lessening the fear of falling foul of accreditation standards, is welcome. (DR p5)*

##### Monash Health

*....the following suggestions could assist;*

*Teaching students a greater understanding of the healthcare context, political influences, government objectives etc. will aid in a great understanding and preparedness for the workplace*

*Teaching students how to respond to and adapt to an ever changing healthcare environment – this includes a greater understanding of how clinicians and teams can proactively manage the increasing burden of chronic disease*

*An expectation that clinical placements include an opportunity for students to practice within teams*

*An avenue for health care services to feed practice trends, issues and changes back to the educators. Both the 'what' and 'how' of service delivery. This would ensure students and graduates are prepared for the potentially confronting issues faced by health practitioners. (DP p4)*

Barriers to the delivery of clinical placements outside traditional acute care settings commonly include cost and time, shortage of resources, development of new partnerships, lack of tradition, difficulties with coordination and negative attitudes and perceptions. In addition, the fees charged by some health services for hosting placements, as well as the costs of travel and accommodation, can negatively impact upon the diversity of settings and experiences available to students.

A further issue that limits broader opportunities is the profession-specific, input-based supervision restrictions outlined in some accreditation standards. For example:

- **Nursing:** [Registered Nurse Accreditation Standards](#) (2012). In the Management of Workplace Experience domain specifies that “*Assessment of nursing competence within the context of the workplace experience is undertaken by an appropriately qualified registered nurse*”. The need for a registered nurse to conduct student assessment is also noted in the domains of Student Assessment and Resources.
- **Psychology:** [Accreditation Standards for Psychology Programs](#) (2017). The Public Safety domain within the accreditation standard requires “*Suitably qualified psychologists supervise psychology students during professional client or organisation contact and provide sufficient hours of supervision to ensure a graduate will be able to practice safely*”. The Psychology Board of Australia defines supervision requirements in their [Guidelines](#) for supervisors and supervisor training providers which specifies a supervisor must have general registration for at least three years, successfully completed training in competency-based supervision and will apply to renew their Approved Supervisor status every five years.
- **Occupational Therapy:** [Accreditation Standards for Entry-Level Occupational Therapy Education Programs](#) (2013). Standard 4.4 under Practice Education/Fieldwork specifies that “*all supervisors of practice education/fieldwork are occupational therapy practitioners with at least one year’s experience, or an experienced occupational therapy educator*”.

Some professions already enable supervision to be provided by health practitioners outside the profession. This is reflected in the [Chiropractic Accreditation and Competency Standards](#) (to take effect 1 January 2018), which states under the criteria for Standard 1 Public Safety, “*1.6. Students are supervised by registered, suitably qualified and experienced chiropractors and/or health practitioners during clinical experience placements*”.

Standardised assessment modules for common competencies may enable the expansion of supervisory roles and clinical placement opportunities and allow students to be supervised by a profession other than their own. As noted in the Australian Rural Health Education Network submission:

*“a critical factor in the ability to offer programs that respond to healthcare priorities is the use of flexible interprofessional supervision arrangements that take account of the nature of clinical practice being provided, the training level of the student, and access to remote supervision through video-conferencing for a proportion of the training time”.* (DP p5)

Submissions to the Draft Report generally agreed that clinical placement experiences should mirror future service reform models and workforce priorities. As noted by the Faculty of Pharmacy, University of Sydney, the desired outcome of a clinical placement is that “*students (are) assessed for their competency to work in a range of practice settings and communities*”. (DR p3) Swinburne University also noted that:

*“This focus on acute settings has the unintended consequence of creating a short supply of placements in hospitals, whereas a greater focus on community settings would better equip students for broader employment opportunities and for eventual practice in the settings in which most health care is delivered. We do acknowledge however the greater difficulty of obtaining appropriate clinical supervision in community settings as opposed to acute settings”.* (DR p4)

Given the link between work experience opportunities and potential employment, accreditation authorities could provide greater leadership and support for education providers to seek out clinical placements that expose students to future models of care and workplace environments. This may constitute cross-professional, evidence-based, best-practice principles that consider supervision models and a focus on learning outcomes.

## Accreditation assessment of quality clinical placements

Ensuring the quality and appropriateness of clinical placements is important for patient and student safety, and for achieving placement outcomes. All health professions accreditation standards reference clinical education with varying content and terminology that specify, for example:

- the provision of a range of different practice education opportunities
- duration and timing within a program of study
- supervision requirements and staff training or educational experience
- requirements for achievement of learning outcomes
- incorporation of simulation-based education and training

- administration between education providers and placement facilities
- appropriate safeguards for patients and students.

It is understood that an accreditation assessment of clinical placements within a program of study would expect to observe policies and procedures, identification of learning outcomes and assessment modalities, and supervisory skills of staff. In some instances, education providers are also required to report on de-identified individual student placements to demonstrate experience across a range of environments and settings. Recognising that breadth of practice is important, the burden of reporting needs to be balanced with quality assurance requirements and flexibility in placement settings that align with evolving community needs.

As noted earlier, accreditation of health service organisations against the NSQHS Standards includes many of the environments in which professional-entry students undertake clinical placements and interns and specialist trainees complete supervised practice. While NSQHS Standards do not examine a health service from an education perspective, the ACSQHC supports the proposal to develop an education module to extend assessments of the NSQHS Standards to include certain clinical educational environments.

*“The Commission notes that, while there are profession- specific and specialty-specific requirements of the work experience location, there is also a set of common requirements across the health professions that relate to governance, facilities, policies and procedures in the work place. Many of these aspects of the work place environment are also important features of the systems for safety and quality in health care services and health services need to demonstrate that they meet relevant requirements within the National Safety and Quality Health Service (NSQHS) Standards. The Commission agrees that there are opportunities to reduce duplication and improve consistency in the accreditation of quality clinical placements”.* (DR p 8)

Accreditation authorities, including specialist colleges in their assessment of training posts, could adopt the findings of these agencies as part of the overall accreditation process. A standardised system of quality monitoring of clinical environments, across disciplines and placement settings, would create consistency in quality assurance, streamline accreditation assessment, reduce the compliance burden arising from multiple standards and improve the timeliness and ease of reporting. This opportunity is explored further in Chapter 7.

## Innovations in health profession education

The education and training of health practitioners needs to be responsive to emerging technologies and techniques which are advancing future health care service models. Education providers are well placed to keep up with these changes and need to be supported by regulation and accreditation in their endeavours.

Another significant development is the new world of ‘consumerism in healthcare’ where patients are more educated, health literate and engaged. Consumers have access to the ‘internet of things’ and the inter-networking of physical devices which empowers them to monitor their own health. Health professionals need to be skilled in working with more informed patients.

Genomic medicine is also evolving rapidly, resulting in testing and information to personalise the design and management of treatment options specifically to the patient. This is transforming patient-centred care through improving diagnoses and targeting treatments and can increase disease prevention. The health workforce needs the skills to understand the opportunities and risks, and to navigate and communicate the options to patients.

Technologies also translate into innovative modes of education and training delivery. Digital learning tools enhance learning outcomes such as interactive learning modules and resources, and communication modalities support a distance-learning experience. Health Education England has established a technology enhanced learning programme to recognise that technology can be used effectively and appropriately to *“enhance the learning of healthcare professionals for the benefits of patients”* ([Technology enhanced learning](#)).

Simulation-based education and training (SBET) is gaining acceptance as an evidence-based education modality that can develop skills, confidence and problem-solving abilities in a safe, controlled and monitored environment ([Solymos](#), 2015). 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). Simulated Learning Environments (SLEs) are recognised as particularly useful to introduce students to critical care situations ([Solymos](#), 2015) and team-based, interprofessional scenarios ([Davis](#), 2016). Simulation scenarios can be used to assess performance and competence and, with well-trained educators and appropriate coordination and support, may expand clinical learning opportunities and alleviate pressures on health services to provide clinical placements. Nonetheless, interactions with ‘real-world’ clients and situations are essential for the development of empathy and communication skills ([Leonard](#), 2004).

Current accreditation standards vary in their acceptance of simulation as a standard component of the health curricula. Examples include:

- **Podiatry:** [Accreditation Standards for Podiatry Programs for Australia and New Zealand](#) (2015) notes 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) 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, notes 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*”.

A number of submissions to the Discussion Paper identified the value of simulated experiences.

#### Box 5.6. Use of Simulation-based Education and Training

##### Australian Private Hospitals Association and Catholic Health Australia

*Simulation-based learning is essential, and should be included as a tool in curricula and clinical experience provision to students. It is especially valuable to provide multidisciplinary training opportunities. Having said that, it is important to stress simulation should be one of the tools, and should not be the only way students receive clinical experience. It is not acceptable to rely on simulated learning as a substitution for adequate clinical placement.* (DP p6)

##### Australian Dental Council

*The ADC considers this a matter for educators and as an accrediting authority we must ensure only that we are not a barrier to the incorporation of contemporaneous or innovative education methodologies. All entry to practice level dental programs will definitely include a strong element of simulation.* (DP p28)

##### Australian Pharmacy Council

*Schools of Pharmacy use simulations as a key part of pharmacist education, and we recognise the importance of this. Our standards rightly state that simulation can support the placement experience, but not fully replace this. In particular, simulation has a role in first experiences in pharmacy.* (DP p26)

##### Edith Cowan University

*The special value of simulation-based learning is that the environment and what happens within, can be manipulated in line with the learning objectives, unlike in real life. ECU believes that the NRAS is the most appropriate instrument for furthering the uptake of SLEs in Australian health professional education. There needs to be explicit recognition of the benefit of these learning experiences within accreditation processes across disciplines so that higher education providers feel confident in embedding them within programs.* (DP p18)

##### Department of Health and Human Services Tasmania

*Simulation is a good example of a wide training variation across the professions. Successful use of simulation education could be translated to great effect in terms of driving innovation in education methodologies to support the delivery of health services into the future.* (DP p3)

Health Workforce Australia (HWA) made significant investments in facilitating the use of SBET. The focus of its Simulated Learning Environments Program was to “*look at innovative and affordable ways to deliver clinical training*”. This included building the evidence for simulation, enabling the adoption of simulation and expanding simulation capacity to increase physical SLE resources and numbers of trained staff. Despite the scope and funding of the program, the Review is not aware of any enduring overarching national approach or guidelines for the use of simulation in education and training since the agency has been abolished.



Simulation represents just one innovative education and training modality, amongst many ever-evolving technologies in pedagogical instruction. To facilitate the continuous development of a flexible, responsive and sustainable health workforce and to enable innovation in education, as set out in the National Law objectives, accreditation standards and assessment processes should promote and encourage education providers to incorporate evidence-based technological and pedagogical advances in the delivery of programs of study.

### Recommendation

12. Accreditation authorities should, within an outcome-based approach to accreditation standards and assessment processes, encourage:
  - a. clinically-relevant placements to occur in a variety of settings, geographical locations and communities, with a focus on emerging workforce priorities and service reform
  - b. evidence-based technological advances in the curricula and pedagogical innovations in the delivery of programs of study.

## The delivery of work ready graduates

The primary objective of a health profession education program is to produce a graduate who has the knowledge, skills and professional attributes necessary to practise the profession and who has an appropriate foundation for lifelong learning.

However, there is a lack of definition about what ‘is necessary to practise the profession’ (or what it means to be work ready). In any business or service, new graduates are not expected to immediately demonstrate the capabilities and knowledge of experienced practitioners. Most employers provide orientation, mentoring and further education to assist new graduates to develop skills and to acclimatise to a workplace. The literature, supported by feedback from consultations, notes that the areas that employers identify as ‘work-ready gaps’ of graduates seem to primarily relate to functioning as a professional within a system, rather than to a lack of 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.

### Supervised practice

For most registered health professions, the completion of an approved program of study meets the education and training requirements for general registration. There is, however, provision in the National Law (s52) whereby a National Board can establish a registration standard which requires a period of ‘supervised practice’ or internships should it so wish. The National Law also permits a National Board to require completion of an examination as a prerequisite for general registration. There can be compelling reasons for why some National Boards have exercised these provisions, though the evidence-base is not always clearly demonstrated.

The AHWMC has approved supervised practice requirements as provisional registration standards under the National Law (s52(b)) for the professions of medicine, pharmacy and psychology. The respective National Boards have established a category of provisional registration to differentiate graduates who are undertaking supervised practice (internship) programs from registered practitioners and students. All internship programs require, in the first instance, mandated time spent under supervised practice. There is little to no capacity for individuals in the programs to demonstrate competency ahead of serving that requirement.

Medicine and pharmacy require a 12-month internship following graduation, and psychology provides for a triple pathway through either completion of a higher (six-year) degree or lesser length degrees (four or five years) with a two or one-year internship. The AHPRA and National Boards submission to the Draft Report expanded on the purpose of provisional registration:

*“Provisional registration enables individuals who are qualified for general registration to register and enter the paid workforce before they have the depth of experience required to practice fully without supervision of some areas.... Interns are not students – they are employees who need some structured supervision to protect the public. The use of internships in the medical and pharmacy professions is international practice and interns make a valuable contribution to the health workforce”. (p6)*



The National Law is clear regarding the differences between registration and accreditation standards and states, “A registration standard may not be about a matter for which an accreditation standard may provide” (s38(3)). Analysis of supervised practice programs by this Review indicate, however, that the boundaries are blurred.

### *Current supervised practice requirements*

The registration standards governing [medicine](#), [pharmacy](#) and [psychology](#) internship all mandate experiential learning, supported by curriculum and/or training plans.

The Pharmacy Board of Australia (PBA) requires graduates to complete a program of study approved by the Board (the undergraduate degree) then undertake a year of supervised practice (internship). The pharmacy accreditation [standards](#) (p5) state that “the goal of initial pharmacy education is to produce graduates with the requisite knowledge, skills and attributes for entry to an intern training program, to provide a sound foundation for further advanced training, and to engender a commitment to lifelong learning”. Graduates are required to successfully complete an [accredited intern training program](#), undertake supervised practice (1,824 hours), and pass national oral and written examinations. The Australian Pharmacy Council (APC) has responsibility for accrediting Intern training program [providers](#) and the PBA issues [guidance to preceptors](#) (2015) for supervisors of graduate pharmacists. The Review notes that the approval of preceptors by the PBA is linked purely to the application for supervised practice by the pharmacy intern (p7-8).

The Medical Board of Australia (MBA) requires graduates to undertake specified periods in accredited training posts. The MBA in 2014 delegated the accreditation of Postgraduate Medical Councils (PMCs) (who accredit intern training posts) to the AMC against [National Standards](#). PMC accreditation of training posts is based on the [National Intern Training Framework](#) (2016) and the [Prevocational Medical Accreditation Framework](#) (2009). This is supplemented by work of the [Medical Deans](#) (2012) identifying the expected competencies of graduates and the [Australian Curriculum Framework for Junior Doctors](#), which identifies the core competencies and capabilities expected from interns and prevocational trainees. The Intern Training Framework approved by the MBA includes domains, [standards](#) and [assessment criteria](#). The [Guide](#) for Intern Training and [supporting documents](#) all set education and training requirements reflecting a vocational or workplace based training program.

The Psychology Board of Australia (PsyBA) registration model requires some graduates to complete hours of supervised practice, which includes specified hours of client contact, supervision and professional development. Its [intern](#) programs are for graduates who undertake a four-year approved program of study (minimum 3000 intern hours) or a five-year approved program of study (minimum 1500 intern hours). The internship programs include [requirements](#) for each internship pathway (one or two-years of supervised practice). Unlike the MBA and the PBA, the PsyBA has not delegated any aspect of its internship program to the Australian Psychology Accreditation Council (APAC). The PsyBA also advised in its submission to the Draft Report:

*“Psychology students do not undertake any clinical education or applied clinical practice in undergraduate study and are therefore unable to demonstrate competence across all areas without completing supervised practice”. (DR p4)*

### *The need for a business case*

While a structured, supervised transition to practice may make a fundamental contribution to the delivery of safe quality care by registered practitioners in some professions, provisional registration is nonetheless a restriction on practice. It places additional requirements on graduates, employers and supervisors, and impacts on the cost of training and on overall workforce supply pipelines. The requirement, and the form it takes, requires transparent justification.

The Review sought feedback from stakeholders on this issue, as well as on the broader question of work readiness (Box 5.7). The prevailing view was that work readiness was multifaceted and included the knowledge, skills and professional attributes developed during education as well as through experience.

#### Box 5.7. Perspectives on supervised practice and work readiness

##### **Australian Private Hospitals Association and Catholic Health Australia**

*It is recognised across the board that employers are responsible for some level of induction as well as continuing professional development for the newly registered professionals they employ... Registration requirements must define a minimum expected set of outcomes and competencies a graduate in any profession will have at the outset. (DP p7)*

## Box 5.7. Perspectives on supervised practice and work readiness

**Australian Dental Council**

*Employers of newly qualified dental practitioners should have the expectation that they will be working at threshold level. The responsibility of an employer is to induct employees into their workplace in order to assure the employees are only undertaking roles and tasks which the employer is satisfied the employee is competent to undertake. This is no different to a day one graduate of an engineering, legal or accounting qualification. This is also sometimes considered ‘credentialing’ in public health services and would take into account the level of experience of the new graduate in accordance with descriptors relating to pay levels. These are expected skills/competence for their employment but not necessarily an expected professional competency on graduation. (DP p29)*

**Pharmacy Guild of Australia**

*The internship program allows graduate pharmacists to develop the academic knowledge they have acquired in the context of a supportive environment that ensures public safety. It offers intern pharmacists the opportunity to practise and develop their practical skills, building upon their academic knowledge under the supervision of a registered pharmacist thereby ensuring the safety of the public. (DR p5)*

**Australian Medical Students Association**

*The medical internship and its accompanying “provisional registration” is an essential part of medical training, and cannot be duplicated by university experiences. Already, graduates find the jump into clinical practice, even on a provisional basis, stressful and significant, and this recommendation fails to understand the usefulness of the stepwise transition to independent practice for doctors. (DR p4)*

**Australian Council of Deans of Health Sciences**

*If a profession requires an intern year, graduate program or supervised practice, this should be at postgraduate level, such as a Graduate Certificate, as it extends and advances knowledge within an Australian Qualifications Framework..... Members also suggest that the rationale, learning outcomes and assessment for such programs of study need to be clear. Embedding such programs within an accreditation framework would assist with this. (DR p7)*

**Medical Deans Australia & New Zealand**

*The threshold issue is the definition of work readiness as there are different understandings as to what is meant by work readiness. Assessing work readiness is also complex. It requires the specification of the instruments that will be used for that purpose; standard setting the assessment at an appropriate level for a medical student; development of related assessment tools; determination of appropriate assessors; training and calibration of assessors to ensure a consistent approach. Universities and health services are working more closely together on the issue of work readiness. (DR p5)*

**Edith Cowan University**

*In principle, ECU supports a period of supervised practice in certain health professions, although it should be understood that supervised practice often occurs prior to graduation as part of mandatory clinical practicum requirements....There needs to be a clear distinction between the skills and competencies expected of a recent graduate compared to the more advanced skills required of an employee with more workplace experience. Requirements to work within a specific site, such as a specific hospital or type of health provider, are the responsibility of the employer, as are on-the-job training and induction programs. (DP p18)*

**SA Health**

*Commencing work as a novice practitioner following graduation from a relevant educational program is a very significant transition in the life of all professionals, and it is not surprising that structured programs have emerged in a number of professions to support this transition. However, mandated programs limit flexibility, may tend to imply that skills at the level of a new practitioner are not required prior to entry, may create significant demands on health services providing programs, and may also cloud the fact that managing transitions will be an ongoing process throughout professional life. (DP p3)*

A national assessment of medical intern training in Australia was undertaken by AHMAC in 2015. That review examined the current medical internship model and considered potential reforms to support medical graduate transition into practice and further training. Its [findings](#) noted that there was value in “*structured, supervised transition to practice that enables medical graduates to assume increasing responsibility for patient care as their capability matures*”. (p4) In its submission to the Draft Report, the AMC reiterated these findings:

*“That Report restates the value of a structured, supervised transition to practice that enables medical graduates to assume increasing responsibility for patient care as their capability matures, and the importance of doctors having a broad foundation of general capabilities and experience. The joint AMC/Medical Board of Australia survey of medical graduates’ preparation for internship will provide additional information that will assist the AMC and the MBA to review the standards for primary medical programs and for internship”.* (DR p5)

The APC also advised of work underway with the PBA to review and improve supervised practice programs:

*“...The APC currently accredits Intern Training Providers for the PharmBA; these standards will be reviewed in 2018, and consideration of the whole continuum of “programs of study” for pharmacists will be discussed at that point. One of the important considerations that we will be considering is how we ensure that internships are conducted in high- quality learning environments, and the PharmBA is currently conducting a pilot survey of interns and preceptors to investigate current issues. We are also using our international links with pharmacy educationalists in the UK, who are working with the Health Education England Quality Framework 2017-18, and this may assist us in development of our own standards”.* (DR p6)

National Boards and AHPRA in their joint submission to the Draft Report also highlighted:

*“We support strengthening transparency and accountability and in this context, the procedures for development of registration standards could be updated to require National Boards to clearly articulate the need for supervised practice requirements and national examinations. The current requirements for intern programs and examinations are regularly reviewed, and these review processes could also provide an opportunity to better articulate the reasons for relevant requirements”.* (DR p6)

This Review notes that the above-mentioned processes to review existing supervised practice arrangements will facilitate regular scrutiny and continuous improvement. The question of whether these supervised practice arrangements should be under the oversight of the accreditation authority or National Board is explored next.

### *Supervised practice versus formal education programs*

Post graduate training that addresses gaps in work readiness and provides mentoring and support for students in the early phases of employment can assist graduates to consolidate prior learning, operate safely, effectively and with confidence. This training could be delivered as:

- workplace-based training programs (vocational training) with learning outcomes and competencies to be achieved within a period of time
- opportunities to practise under supervision where the graduates improve their competence by practising the knowledge, skills and professional attributes gained during the undergraduate years.

For all of the internship programs, there are clear expectations of curricula, assessment processes and competency requirements, which are similar to those expected from accredited programs of study. This blurs the boundaries between what would be considered a period of practice under supervision or a workplace-based vocational training program. Existing provisional registration standards include elements of both.

Decisions by National Boards to establish additional requirements for pre-general registrants should require justification and scrutiny in the form of an assessment which:

- demonstrates the requirements of postgraduate competencies at profession entry level that can be differentiated from normal and expected progressive work experience
- provides evidence that the approved accreditation standard is unable to ensure the delivery of the knowledge, skills and professional attributes necessary to practise the profession, even after amendment
- establishes and documents whether there is a requirement for supervised practice or vocational training and specifies the expected learning outcomes and how they will be assessed
- specifies if the supervised practice or vocational training warrants a category other than general registration and the limitations of that registration.

Where internship programs are established as vocational training programs, they should be recognised as programs of study and subject to monitoring and oversight by the relevant accreditation authority. The Review notes that this already occurs with medicine and, to a lesser degree, with Pharmacy. Expertise rests with the accreditation authorities and the Review suggests that the Pharmacy and Psychology Boards review current arrangements accordingly. This is particularly relevant for Psychology, as noted by the Heads of Departments and Schools of Psychology Association in its submission to the Draft Report:

*“The +2 and the +1 are not designed to ensure that already trained professionals become more rounded and work ready. They are THE training, especially in the case of the 4+2 program. The +2 comprises of an agreed program that covers a curriculum set out by the Psychology Board of Australia for training a ‘generalist’ psychologist. Likewise, the +1 is an agreed internship that covers the same curriculum in trainees who have already completed a 1-year Master program at a University/Higher Education Provider”.* (DR p4)

## National examinations

Domestic pharmacy graduates are required to pass additional national examinations, as are all graduates of the four- and five-year psychology degree courses. National examinations are a cost to the student, with pharmacy graduates paying \$1,018 (includes oral and written components) and psychology graduates paying \$450.

Pharmacy interns sit written exams following 30% completion of internship (conducted by the APC) and oral exams at completion of 75% of internship (conducted by the PBA). The [written exam](#) is a multiple-choice questionnaire and the oral exam requires demonstration of knowledge through role-play or discussion.

Psychology graduates of the five-year degree can sit the exam at the commencement of the supervised practice year and graduates of the four-year degree upon completion of 1,540 hours of supervised practice. Exams are based on an [examination curriculum](#) that is “*designed to test applied knowledge appropriate for the fifth and, in particular, the sixth year of psychology training*” (p1). The [exam](#) comprises 150 multiple-choice questions, based on the domains of the examination curriculum (ethics, assessment, intervention and communication).

The pharmacy and psychology examinations are set during the period of supervised practice for administrative reasons. As noted by the Psychology Board in its submission to the Draft Report:

*“The exam is available to be sat approximately 70 days per year, spread over four months (February, May, August, November). This was an operational decision, made in response to feedback, not a policy decision in regards to the purpose of the exam. In practice, candidates typically apply to sit the exam within the final months of their internship, just prior to applying for general registration”.* (DR p4)

Such examinations follow on from completion of accredited programs of study. There is an argument that 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.

Conversely, health profession accreditation standards already outline the need for evidence-based assessment mechanisms, undertaken by appropriately trained assessors. Standard 26 of [Pharmacy accreditation standard](#) already requires a range of assessment methods appropriate to the outcomes of the program. Similarly, the [Psychology accreditation standard](#) include a specific domain for ‘Assessment’.

While some submissions to the Review supported national examinations, generally the need for them was questioned, especially given that the accreditation process evaluates assessment methodologies already included in programs of study.

### Box 5.8. The value of national examinations

#### CQUniversity

*A system of national examinations could allow for the streamlining of accreditation processes. In a model of a single accreditation agency applying a common set of accreditation standards and processes, a national examination could facilitate the move away from cyclical accreditation reviews ... if after that the accreditation system moved to a system of risk-based monitoring a national examination could be used as a key mechanism for monitoring programs against nationally agreed benchmarks. A national examination could therefore be used to facilitate the streamlining of accreditation processes in a move toward a risk-based approach, although it would not be a necessary pre-condition of such a move.* (DP p7)

## Box 5.8. The value of national examinations

**Psychology Board of Australia**

*Examinations have a different purpose to accreditation. Accreditation is more "formative" in that it outlines evidence for institutional quality assurance of the curriculum and overall student experience, whilst an exam is "summative" in that it tests actual individual performance. One should lead to the other, therefore there is a need for both accreditation and examinations along the pathway to ensuring work readiness. They serve different functions but both are requisite. (DP p4)*

**NSW Health**

*A national assessment may address the issue of variability however it may not address the issue of work readiness if the assessments were not valid. The easiest way to administer national assessment is via multiple choice examination, however that process may not be appropriate for assessing non-technical skills such as teamwork and communication skills. Further clarification of medical graduate outcomes with a more robust accreditation process would better address issues concerning work readiness. (DP p7)*

**Faculty of Medicine, The University of Queensland**

*A robust accreditation process should negate the need for further national assessment to gain general registration. It is likely that a national assessment process would be in addition and not instead of existing accreditation processes. We would recommend that further research is needed in Australia to determine whether a national assessment would add value to our current accreditation system and that this study should draw upon the experience and evidence from other countries. (DP p4)*

**Optometrists and Dispensing Opticians Board New Zealand**

*The Board is not persuaded that national examinations should be introduced as a useful way to determine the educational quality of programmes of study. The Board believes that valid and reliable assessment methods are best evaluated within the overall context of assessment in the specific programmes of study. This is in line with the risk level of the particular profession, rather than in line with an abstract uniform standard. The cost of such examinations is also bound to fall on the student, which for the profession of optometry, could deter students from entering the workforce. (DP p3)*

The National Boards/AHPRA joint submission to the Discussion Paper acknowledged that a robust accreditation process should negate the need for further assessments:

*"We do not consider a national assessment process allows for a more streamlined accreditation process. It would introduce an unnecessary regulatory requirement because the accreditation arrangements under the National Law are designed to ensure graduates of accredited programs have achieved the Board's expectations of graduate competence". (DP p11)*

Examinations are useful in assessing the knowledge, skills and professional attributes of overseas trained practitioners in that they enable a consistent approach to assessing learning outcomes from varying education and training programs against competencies expected from domestic graduates. National examinations have also been used in jurisdictions such as the United States of America and Canada, where there is not a national approach to accreditation of programs of study.

National examinations can also be useful if they assess competencies gained during periods of supervised practice or post-graduation vocational placements. Where, however, such examinations are seen as a response to deficiencies in undergraduate or internship programs, those should be addressed in the first instance. The Review makes the observation that any rationale for imposing national examinations, and the supporting evidence-base, should be clearly demonstrated.

## Recommendations

13. National Boards that wish to set requirements for general registration additional to domestic qualification attainment should:
  - a. demonstrate the requirements of postgraduate competencies required at profession-entry level that can be differentiated from normal and expected progressive work experience
  - b. provide evidence that the approved accreditation standard is unable to ensure delivery of the knowledge, skills and professional attributes necessary to practise the profession, even after amendment
  - c. establish and document whether there is a requirement for supervised practice or vocational training and specify the expected learning outcomes and how they will be assessed
  - d. specify if the supervised practice or vocational training warrants a category other than general registration and the limitations of that registration.
14. If National Boards set requirements for general registration additional to domestic qualification attainment that require further vocational or academic education, these requirements should be defined as programs of study and accredited by accreditation authorities.

## 6 Accreditation governance – foundation principles



Previous chapters have examined opportunities to improve the cost-effectiveness of accreditation and the relevance and responsiveness of health education. Some of the reforms proposed by this Review are not new, nor are the problems they are seeking to address. These next two chapters focus on whether reform of the underlying governance of accreditation is required for those reform proposals to be progressed in a timely manner through the collective and collaborative approach of all entities. Chapter 6 establishes the foundational principles of a fit-for-purpose governance approach.

### Key messages

Regulatory responsibility should not be duplicative and decisions should be made by those with the appropriate expertise.

Responsibility for the regulation of the accreditation functions under the National Law should be better defined and separated from that of the regulation of individual practitioners.

There should be a collective and collaborative approach by all National Scheme entities to achieve the National Law objectives.

Statutory decision making should be made independently of the regulated parties and other interested stakeholders. Any approach to ensuring this independence should be largely agnostic as to the governance structures of accreditation councils.

All accreditation decisions should be transparent and be subject to statutorily prescribed scrutiny.

Governance arrangements must be designed to be able to support potential future amalgamation of accrediting bodies for efficiency and effectiveness purposes should such amalgamation be agreed.

### Origins of the current governance arrangements

The [Productivity Commission](#) (2005) identified the regulatory separation of accreditation and regulation as being good practice:

*“... 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”. (p122)*

The March 2008 COAG [Intergovernmental Agreement](#) for a National Registration and Accreditation Scheme for the Health Professions’ referred to its 2006 decision to establish registration and accreditation as two distinct activities. In responding to the Productivity Commission’s 2005 Report, the agreement noted:

- 2.2 *The report recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training; to deal with workforce shortages/pressures faced by the Australian health workforce and to increase their flexibility, responsiveness, sustainability, mobility and reduce red tape.*
- 2.3 *At its meeting of 14 July 2006, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions.*



- 2.4 COAG further agreed to establish a single national accreditation scheme for health education and training, in order to simplify and improve the consistency of current arrangements.
- 2.5 COAG has subsequently agreed to establish a single national scheme, with a single national agency encompassing both the registration and accreditation functions.

In accordance with the intergovernmental agreement the role of the AHPRA is to set frameworks and requirements for the procedural development of registration, accreditation and practice standards by National Boards and to ensure good regulatory practice, in accordance with the legislative objectives and policy directions of Health Ministers. AHPRA has no role in decisions made by National Boards.

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 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 assignation 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.*

The finally agreed National Law required the assignment of accreditation functions to be reviewed within three years. However, the Law critically shifted responsibility for determining how the functions would be delivered on an ongoing basis 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).

## The relationship between accreditation and registration

The National Scheme encompasses two functions - the accreditation of health programs of study and providers, and the registration of individual health practitioners. Accreditation is a fundamental antecedent to registration. Assessing how these functions operate and interrelate is central to the assessment of governance.

As outlined earlier in this report, accreditation functions cover the:

- development of accreditation standards by accreditation authorities for submission to the relevant board for approval and publication of the approved standards
- accreditation of programs of study and providers by accreditation authorities against those accreditation standards and then approval of those accredited programs of study by national boards as providing qualifications for the purposes of registration
- assessment and approval of authorities in other countries that would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia
- assessment of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession.

Accreditation provides the threshold assessment and evaluation of education and training courses to assess whether graduates have the knowledge, skills and professional attributes necessary to practice the profession in Australia – with that legal right to practice being then dependent on registration by the relevant National Board. Under the National Law, the National Boards are the final decision makers on the accreditation standards and programs of study:

- While each council/committee develops accreditation standards, they must submit them to the 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).
- A National Board may also approve an overseas qualification if it considers it to be substantially equivalent or based on similar competencies to an approved qualification (s52).

The joint National Boards/AHPRA submission to the Discussion Paper describe this intrinsic link between Board approval of accreditation and its registration decisions in the following terms:

*“The regulatory system established by the NRAS creates an intrinsic link between Board approval of accreditation standards, accreditation decisions and National Boards’ decisions on eligibility of practitioners for registration. That is, in order to effectively regulate practitioners within the flexible framework of the National Law, a National Board relies on assessment against accreditation standards that it has approved or examinations and assessments that it has approved. Reforms that decouple this link create inherent risks to the integrity of the NRAS regulatory system. Many National Boards and Accreditation Authorities have long-standing and effective mechanisms that reflect this link and are critical in achieving the objective of the National Law 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”. (DP p12)*

A threshold question for this Review is whether accountability for accreditation should be at the accreditation function level or, as at present, at the registration level where accreditation functions are, in practical effect, the responsibility of a National Board with some services performed by a Committee of a Board or delivered by a contracted provider (council).

In both perception and operation there are variations of view on the degree of independence of accreditation authorities from National Boards under the current National Scheme.

The [Ministerial Council Communiqué](#) of 8 May 2009 refers to ‘independent’ accrediting bodies but makes clear that final decisions on accreditation ‘for the purposes of registration’, are to be taken by the National Boards:

*“The Ministerial Council agreed today that the accreditation function will be independent of governments. Accreditation standards will be developed by the independent accrediting body or the accreditation committee of the board where an external body has not been assigned the function.*

*The accrediting body or committee will recommend to the board, in a transparent manner, the courses and training programs it has accredited and that it considers to have met the requirements for registration. The final decision on whether the accreditation standards, courses and training programs are approved for the purposes of registration is the responsibility of the national board. The accrediting body will have the ability to make its recommendations publicly available in the circumstance that agreement between the accrediting body and the national board cannot be achieved”. (p1)*

This approach has led to a view that the decision to accredit a program and the decision to approve it for registration purposes each have meaning in practice. For instance, in 2015 AHPRA issued a [guidance document](#) for accreditation authorities and National Boards concerning accreditation and program approval decisions and changes to accreditation standards. It states:

*“The National Board does not make the accreditation decision, that is, it does not assess the evidence and decide if the program and provider meet or substantially meet the accreditation standards. It does however use the Accreditation Authority’s report on the accreditation to make a decision on approval of the accredited program”. (p3)*

The Joint Response from AHPRA and 13 National Boards to the Draft Report expands on this:

*“The National Law separates the accreditation functions (exercised by accreditation authorities) from functions related to regulation of individual practitioners (exercised by National Boards and AHPRA). This creates two distinct but connected areas of regulatory focus... National Boards cannot change accreditation standards developed by the accreditation authorities. Accreditation authorities make decisions under the National Law to accredit programs of study with or without conditions. National Boards cannot change and do not approve these decisions. National Boards do not assess or accredit domestic programs against accreditation standards – these accreditation functions are solely exercised by accreditation authorities”. (DR p10)*

The Review is not satisfied that the practical effects of the National Law provisions are as suggested by AHPRA and the National Boards. Under s47 a National Board cannot change an accreditation standard, but it can (and has) either refuse to approve a standard or request that it be reviewed. Given that s47 provides that an accreditation standard cannot take effect until it has been approved by a National Board and published on its website, the development of a standard by an accreditation authority has little separate meaning in practice.

Similarly, s49 of the National Law provides that a National Board may approve or not approve an accredited program of study as providing a qualification for the purposes of registration. Whilst the term “accredited program of study” is defined under the National Law, it has no practical meaning by itself under the National Law

or under any other legislation or education framework. The National Law requires that Australian trained registrants must complete a program of study approved by a National Board as described under s49. Further, the legislative requirement for monitoring of programs of study only applies to those programs that are approved by National Boards under s49.

Both s47 and s49 provide that, if a National Board refuses to approve a proposed accreditation standard or an “accredited” program of study respectively, it must provide written advice of the refusal and the reasons and the accreditation authority is entitled to publish any information it gave to the National Board in seeking that approval. It is unclear as to the purpose of these provisions, given there is no dispute resolution mechanism and the authority to approve both accreditation standards and programs of study for all the purposes under the National Scheme rests singularly with National Boards.

The recognition of a health profession qualification in Australia’s education and training sector similarly relies on National Board approval.

- The Higher Education Standards Framework ([Threshold Standards](#)), established by s58 of the Tertiary Education Quality and Standards Agency Act 2011, at Standard 3.15 requires “*where professional accreditation of a course of study is required for graduates to be eligible to practise, the course of study is accredited and continues to be accredited by the relevant professional body*”. The Australian Qualifications Framework ([AQF](#)) defines accreditation as “*the process for approval by an accrediting authority of a program of learning leading to an AQF qualification using the quality assurance standards for the relevant education and training sector*”. (p91)

The terms ‘relevant professional body’ and ‘accrediting authority’ are not further defined under the Threshold Standards. However, the accreditation standard is designed to encompass both statutorily regulated and self-regulating professions. Both TEQSA and self-accrediting universities advise that, in the case of regulated health professions under the National Scheme, it is understood in practice that if a course has not received approval by a National Board for the purposes of registration it cannot be accredited as a higher education qualification under the AQF.

- In the [Standards for VET Accredited Courses](#), Standard 7.5 requires recognition to be given to the course by the applicable licensing, regulatory, professional or industry bodies for it to be recognised as a qualification under the AQF.

From the professional accreditation perspective, either accreditation of the qualification in the AQF by an authorised entity under the Higher Education Standards Framework or registration as an education provider by either TEQSA or ASQA is the common requirement

The Review concludes that under the National Law there are separate provisions for a decision to ‘accredit’ a program of study and a decision to ‘approve’ that program, but the former has no meaning in practice and that, whilst accreditation authorities perform prescribed functions, accreditation authority is held by the Boards.

Given the extensive overlap in both policy and operations between the National Scheme and the national education and training sector and the reliance each has on each other, the Review considers it would be of benefit to review the complementarity of the definitions of accreditation and the usage of the terminology in the two systems, including the National Law’s distinction between an accredited program of study and an approved program of study.

As noted above, the joint National Boards/AHPRA submission refers to the risk of decoupling the “*long standing and effective mechanisms*” that link registration and accreditation. However, the current arrangements by which accreditation approval decisions (for the purpose of registration – being their only practical effect) are functions of National Boards are in many cases a substantive change from long standing operations under previous State and Territory legislation. The provisions of the National Law established roles that are different to those that operated for the accreditation activities of specific professions and in different jurisdictions prior to the National Scheme. There was a range of arrangements:

- Accreditation authorities with the authority to accredit programs of study
- Accreditation authorities submitting programs of study to state and territory registration boards for approval
- Approved programs of study being declared in regulation
- State and Territory Registration Boards running in-house accreditation operations.

The decision to change these arrangements and place final decisions on accreditation in the hands of National Boards came from the 2007/08 work of the COAG Senior Officials Group that culminated in the 2008 Intergovernmental Agreement. The solution was determined largely on two grounds, the first being as a way to standardise arrangements across professions. The second, which will be addressed in more detail in a later section, was as a means to resolve the difficulties surrounding private organisations being granted legislative decision-making powers and the complexity of applying statutory scrutiny requirements to those organisations.

The Review is not satisfied that the only governance structure which would ensure that programs of study produce practitioners with the knowledge, skills and professional attributes necessary to practice the profession in Australia is a single body that has final approval over both accreditation and registration. The Review is also concerned that vesting responsibility in a single body whose primary focus is on protecting the public through the regulation of individual practitioners may not be the best approach to ensuring all National Scheme objectives are being met in a balanced manner. The Review has therefore examined other approaches to the regulation of professions that deliver services requiring public protection.

## Regulatory relationships in other regimes

Cooperation with or reliance upon complementary decision making is a common feature in regulatory schemes and usually occurs when either there is a need to ensure that the specialist expertise is applied to the area being regulated or a regulatory scheme or framework is put in place with multiple objectives.

In terms of reliance upon specialist expertise, the regulation of trades where appropriate entry qualifications are fundamental to public protection varies by jurisdiction (for example the various categories of electrician, plumbing and gas fitting occupations). However, in all cases there is an agreed national approach to accreditation which accepts the decisions of a separate regulator. The regulating entities do not seek to separately determine qualification accreditation standards or assess individual courses but accept the determinations of ASQA as the national VET regulator.

In the case of tertiary qualified professions, the Commonwealth Tax Practitioners Board (TPB), for example, regulates tax agents, BAS agents and financial advisers Australia-wide. It has adopted the same approach as the trades regulators, stating in its information sheet [TPB i 07 2011 Approval Process for Course Providers](#):

6. *The TPB is of the view that where a course is provided by a university, RTO or other registered higher education institution (for example, a non self-accrediting higher education institution), there are:*
  - o *sufficient quality assurance safeguards in place to ensure that the course is provided according to appropriate professional and educational standards*
  - o *the course provider has sufficient internal mechanisms to be sustainable.*
7. *The TPB recognises that universities are subject to regulatory activities and quality assurance mechanisms undertaken by the Tertiary Education Quality and Standards Agency (TEQSA). TEQSA has been established as an independent body with powers to regulate university and non-university higher education providers, monitor quality and set standards.*
8. *Similarly, the TPB recognises that RTOs are subject to regulatory activities and quality assurance mechanisms undertaken by the Australian Skills Quality Authority (ASQA), the national regulator for the vocational education and training (VET) sector.*

The trade regulators and the TPB referred to above play critical roles in setting knowledge and skill requirements for entry into the respective profession and yet they also understand, accept and work with other responsible entities, within and outside their individual regulatory environments, to manage threshold qualification matters that are intrinsic to the practitioners being registered.

In terms of where there are multiple and sometimes competing objectives, a significant example of best practice role separation, balance and cooperation in regulation is Australia's model for the regulation of the financial system. Named the "Twin Peaks" model, it is being emulated worldwide. (To date, other countries that have adopted the model include the United Kingdom, the Netherlands, Belgium, New Zealand, Qatar and South Africa and those that have signalled an intent to adopt it include South Korea, Hong Kong and the federal level of the Eurozone) The model is characterised by two independent peaks: the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA). Crucial to its success is that each regulator has its own clearly defined power and has built its own independent expertise.

The Australian Government addresses the effective operation of this multi-entity regulatory model in the Federal Treasurer's [Statements of Expectations](#) issued to ASIC and APRA with an identical provision:

*“The Government expects that ASIC will maintain robust, effective and collaborative working partnerships with other Commonwealth and State and Territory agencies, as well as APRA’s counterpart regulators in overseas jurisdictions, to ensure the proper functioning of Australia’s regulatory framework. APRA should avoid the duplication of the supervisory activities of other regulators, and should consider whether outcomes could be achieved by using existing regulation administered by another regulator, in order to ensure an integrated regulatory framework and minimise compliance costs”.*

The regulators provide complementary [Statements of Intent](#) outlining how they will meet those expectations.

## Design features for accreditation governance

The Review has identified four key design criteria for a health education accreditation regulatory model that reflect its many component parts and objectives:

- decision making should be made in accordance with National Scheme objectives by those with the expertise in the functional area
- the exercising of those responsibilities is independent of the regulated parties and other interested stakeholders in both reality and perception
- decisions should be transparent and subject to statutorily prescribed scrutiny (refer Chapter 8)
- all entities operate collectively and collaboratively to achieve the scheme objectives, and in particular, National Boards continue to have trust in the integrity of the accreditation institutions and decisions.

The Review has explored each of these criteria and their application in governance of the accreditation system.

## Employing accreditation expertise more effectively

The OECD's [The Governance of Regulators](#), lists the characteristics of good decision making and how this relates to determining the structure of regulatory bodies:

*“All regulators’ decisions and activities should be objective, impartial, consistent and expert”.* (p47)

*“The governing body structure of a regulator should be determined by the nature of and reason for the regulated activities and the regulation being administered”.* (p68)

Under the National Scheme there are currently two distinct domains of regulatory scope:

- regulation of individual health practitioners
- regulation of accreditation standards, onshore and offshore programs of study and the providers of those programs (including the performance of their governance and operational activities). This domain is encompassed by the definition of the accreditation function under s42 of the National Law.

As noted earlier, ultimate authority for both of these domains is currently held by National Boards.

Submissions to the Review on the current and possible future relationship between National Boards and accreditation authorities were limited, with many citing a lack of knowledge on the specifics of current governance structures. Responses that did comment were mixed however, with the particular exception of the joint National Boards/AHPRA submission, the substantial majority considered that National Boards did not have the requisite expertise to undertake their accreditation approval functions and generally supported greater independence in accreditation decision making. Proposed solutions to the issue, however, were varied.

### Box 6.1. National Boards and accreditation

#### NSW Health

*A board’s knowledge and skills can be highly dependent on its individual members, rather than the categories of membership set out in the National Law, which relate largely to jurisdictional practitioner representation. For this reason, there is always a danger that an individual board does not have appropriate knowledge and skills in any given domain. (DP p7)*

## Box 6.1. National Boards and accreditation

**Joint National Boards/AHPRA**

*National Boards are, as part of their functions, responsible for regulating the professions, including determining notifications about professional performance. National Boards are keenly aware of the objectives of the National Scheme, including the objectives relating to public protection, access to services and enabling the continuous development of a flexible, responsive and sustainable Australian health workforce and educational innovation... National Boards have the appropriate skills, knowledge and incentives to approve accreditation standards and accredited programs within the framework established by the National Law including consideration of the workforce needs of a rapidly evolving health system. National Boards have regard for the objectives and guiding principles of the National Law and the regulatory principles for the Scheme when they perform these functions. (DP p11)*

**Health Professions Accreditation Collaborative Forum**

*... accreditation is a small part of the work of the National Boards, and the Forum sees that these roles and skills can be awkward additions to the board's other duties. This is complicated by the fact that the national board appointment process is reliant on jurisdictional appointments, not skills-based appointments. (DP p18)*

**Australian Council of Deans of Health Sciences**

*The current constitution of profession specific boards, while having a depth and breadth of knowledge and skills, may lack the incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system. The many responses to this question will perhaps align with the perspective from which they are provided; ranging from maintaining the status quo to innovative responses to changing health care needs. Fundamental health workforce reform may not be a common or priority focus. (DP p22)*

**Council of Deans of Nursing and Midwifery Australian and New Zealand**

*The Nursing and Midwifery Board of Australia is constituted from representation from the States and Territories. Board appointments are made by Ministers, who should be cognizant of the requirements. AHPRA has a separate accreditation policy area that provides advice on matters related to accreditation. The accreditation area in AHPRA appears to be becoming utilised more by the Boards, which appears to support the notion that the National Boards are not constituted for purpose. (DP p5)*

**Council of Ambulance Authorities**

*... some Boards have been guilty of making biased judgements which have impacted on the growth of their particular workforce and limiting broader inter-professional practise and learning. (DP p7)*

**Australian Psychology Accreditation Council**

*... the national Registration Board is not constituted to enable informed approval of accreditation standards. The Board members have been chosen for their expertise in disciplinary and registration functions. Approval of accreditation determinations and accreditation standards, even were they to be governed by better guidelines as described above, are awkward additions to the Board's other duties. (DP p23)*

**School of Psychology, University of Queensland**

*There is insufficient independence of accreditation bodies and their governing boards. This compromises the efficiency of accreditation, with flow-on negative outcomes for the tertiary education providers and for the profession. In 2014 the Australian Psychology Accreditation Council (APAC) initiated an overhaul of the psychology accreditation standards. The new standards were completed and subject to stakeholder review in mid-2014. Following that consultation process, the standards were revised but the final draft has been repeatedly held up as a result of independent input from the Psychology Board of Australia, which appears to have the "last word" on what should be included in the new standards, over and above the public consultation and revision. The back-and-forth between APAC and the Board has resulted in a complete stalling of the new standards, such that institutions are now informed that they will not be available until 2018. (DP p1)*

The National Law does not specify which particular fields of expertise are required by Board members to deliver their functions. It only specifies the ratio of practitioner members to other members and a mandated representation quantum based on jurisdiction size and rural and regional representation.



National Scheme arrangements deliver essentially 14 separate profession-based schemes. AHPRA provides the secretariat and each National Board exercises authority over all matters relating to their profession. Each National Board, whilst operating independently of each other, by virtue of its role and recognised expertise in registration, can be expected to be appropriately risk averse in carrying out that function.

However, the Boards may not necessarily have the expertise in innovations in pedagogy and in the educational foundation needed for a responsive health workforce. Given this, the current governance arrangements for approval of accreditation standards and programs of study for registration purposes have the potential to limit the achievement of the full range of National Law objectives. For example, Objective 3(c) of the National Law requires facilitation of the provision of high-quality education and training of health practitioners; Objective 3(f) requires, the continuous development of a flexible, responsive and sustainable health workforce and Objective 3(e) requires facilitation of access to health practitioner services in accordance with the public interest.

An example of how the balancing of the objectives in the approval of accreditation standards operates in practice can be seen in circumstances set out under s11 of the National Law. Under this section, the Ministerial Council has the reserve power to issue a direction in relation to a proposed accreditation standard if it considers that it will have a substantive and negative impact on the recruitment or supply of health practitioners. This has been identified as a specific element of the National Law objectives of particular importance to governments that may necessitate intervention if it has not been appropriately considered by National Boards. The AHPRA [Procedures for the development of accreditation standards](#), however, interpret the role of National Boards on this matter in a more passive manner:

*"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 s11(4) of the National Law". (p3)*

The National Law requires that National Boards (and all entities) exercise their functions having regard to all the legislated objectives. It would be expected, therefore that, should such a potential impact on recruitment and supply be identified, they would, firstly, apply their power under s47 of the National Law to not approve an accreditation standard or to refer it back to the accreditation authority for review. It is unclear why this would not be the National Boards' default approach when balancing the range of National Law objectives

In relation to the approval of programs of study, as the joint National Boards/AHPRA submission to the Draft Report observed: "...accreditation authorities do not approve qualifications for registration purposes or make decisions on the suitability of individuals for registration – these are registration functions". Whilst this is correct, s48(1) of the National Law is also clear that an accreditation authority has responsibility for accrediting a program of study and in doing so, the authority must be reasonably satisfied:

- a. *the program of study, and the education provider that provides the program of study, meet an approved accreditation standard for the profession; or*
- b. *the program of study, and the education provider that provides the program of study, substantially meet an approved accreditation standard for the profession and the imposition of conditions on the approval will ensure the program meets the standard within a reasonable time.*

An approved accreditation standard is defined under s5 of the National Law as follows:

*"... for a health profession, means a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia".*

Thus the basis for an accreditation decision is clear and the AHPRA [guidance document](#) referenced earlier is equally clear that National Boards do not assess accreditation evidence or decide whether a program and provider meet the accreditation standards. However, while the National Law requires a National Board to provide reasons for a refusal to approve a program of study, there is no information available on what criteria a National Board uses to either approve or refuse such programs. The 2015 AHPRA guidance note states:

*"In making a decision to approve an accredited program, the National Board...should not need to impose any conditions on its approval of an accredited program of study. In most cases, the imposition of conditions by the Accreditation Authority, the Authority's monitoring of those conditions and reporting to the Board, and the other powers available under the National Law should adequately manage the risks that the accreditation standards will not be met". (p6)*



The Review considers that it is unreasonable from the perspectives of accreditation authorities and education providers for National Boards to apply unspecified criteria when approving accreditation standards or overruling an accreditation authority on a matter covered by an accreditation standard.

On the question of expertise, there is strong evidence that the 14 accreditation authorities have the requisite knowledge and skills required to undertake the accreditation functions. This was first demonstrated in the 2012 review of accreditation councils which resulted in the endorsement of their continuation. The review process was developed by the Accreditation Liaison Group (ALG) in consultation with National Boards and accreditation authorities. Common assessment domains were applied, and the threshold test was how well each council demonstrated that it was effectively undertaking the accreditation functions. A review of documentation provided by AHPRA indicates that all councils were considered to be performing the accreditation function well.

The Review concludes that the current governance processes for accreditation approval are, at best, duplicative and unnecessary, and, at worst, could lead to inexpert decisions being made that reject or change an assessment that has been made by an expert accreditation authority on the basis of approved and published standards.

### Applying accreditation expertise to the assessment of overseas trained practitioners

Under the National Law, governance of the assessment of overseas trained practitioners and authorities lacks clarity. The assessment is both a registration and an accreditation function and can be undertaken, as determined by a National Board, by itself or an accreditation authority.

As a result, different approaches have evolved. Two National Boards (nursing and midwifery, and psychology) have made a decision not to assign these functions to their respective accreditation council. In the case of medical radiation practice the National Board has an in-house accreditation function (including overseas qualification assessments), however, the approved authority for assessing overseas qualifications for skilled migration purposes is the Australian Society of Medical Imaging and Radiation Therapy. Conversely, the Chinese Medicine Board, which also has an in-house accreditation function, assesses overseas qualifications for both registration and skilled migration purposes. The joint National Boards/AHPRA submission to this Review states:

*“There is not an automatic link between the expertise required for accreditation of Australian programs and the expertise required for assessment of overseas qualified practitioners seeking registration ... There are a range of reasons why some National Boards have not assigned the function to assess overseas trained practitioners to the bodies responsible for accreditation of Australian programs. These include the locus of expertise, volume of applications, impact on applicants and risk profile of the profession”. (DP p15)*

The Review has considered the issues of expertise, volume, impact and professions’ risk profile:

- **Locus of expertise** - it is unclear why an accreditation authority might not be considered to have expertise in assessing overseas programs of study or competent authorities, given that each has been granted the authority, by the National Boards via contracts with AHPRA, to accredit onshore programs.
- **Volume of applications** - the *Cost of Accreditation in the National Registration and Accreditation Scheme* (2016) indicates that in 2015–16, accreditation authorities accredited 746 programs of study across 338 education providers. (p3) From 2013–14 to 2015–16, accreditation authorities assessed 32,411 applications from overseas applicants (p29). Given this volume of activity, it can be safely assumed that accreditation authorities can, and do, deal with high volumes of transactions.
- **Impact on applicants** - this appears to be a concern only when National Boards have chosen not to align skilled migration and registration processes, as significant distress can be caused when applicants who have been assessed for skilled migration by an accreditation authority are then denied registration by the National Board. For example, this occurred in 2014 when the Nursing and Midwifery Board of Australia (NMBA) implemented a new model for the assessment of qualifications for internationally qualified nurses and midwives, which resulted in overseas trained nurses who had been assessed by the Australian Nursing and Midwifery Accreditation Council (ANMAC) for skilled migration purposes being denied 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”.*

The reference to ANMAC in this statement is in relation to its role authorised by the Federal Minister for Education in undertaking qualification assessments for skilled migration purposes. The link between the two assessments is explored in Chapter 8, however, it does not shed any light on why a Board would choose to not assign the responsibility to assess internationally trained practitioners to an entity that accredits onshore programs and, in most circumstances, is nominated by the Federal Minister for Education as the appropriate assessor for skilled migration applications for the profession in Australia.

- **Profession’s risk profile** - the 2014 [NRAS Review](#) noted that the professions of medicine, dentistry, nursing and midwifery, pharmacy and psychology had a higher regulatory workload (p20) and its Consultation Paper indicated that this was based on “*ascertaining the potential risk of harm to the public, and largely calculated this risk on the basis of the number, frequency and significance of the complaints and notifications made against members of the profession*”. (p8) [AHPRA data](#) on notifications and complaints indicate that of the total complaints or notifications, 41.8% were related to clinical care, 11.5% to medication issues and 10.7% to health impairment (p45). AHPRA data further show that the top four professions generating notifications are medical practitioners (53.3%), nurses (19.3%), dental practitioners (10.8%) and pharmacists (5.7%) (p49). Of those four professions, however, medicine, dentistry and pharmacy have international assessments undertaken by the respective accreditation authority and already achieved alignment between qualifications assessments for the purposes of skilled migration and registration. The Review infers from this that the risk profile of a profession is not a significant inhibitor to a one-step and one stop approach to qualifications assessments.

The Review concludes that the rationale offered in the National Boards/AHPRA submission does not withstand scrutiny. There appears to be no basis as to why any of these four reasons might result in a decision to retain this function by the National Board rather than assign it to the relevant accreditation authority. The Review is also concerned that there is substantive risk that an approach that separates the functions could result in different standards being applied to Australian trained practitioners (by accreditation authorities) and overseas trained practitioners (by National Boards).

There are also cost implications in running this dual approach, both to the National Scheme and to applicants. In the National Scheme, whilst AHPRA provides a standalone overseas qualification assessment function for the Nursing and Midwifery, Psychology and Medical Radiation Practice Boards, it was unable to provide advice to the Review on the total cost (apparently due to its consolidated budgetary system). The cost to applicants is covered in a more detailed analysis of qualification assessments for registration and skilled migration in Chapter 8.

The assessment of overseas qualifications is undertaken to ascertain its comparability with approved Australian qualifications. This establishes an objective standard in terms of the knowledge and clinical skills expected from all registered practitioners. Accreditation authorities have expertise and established processes to assess programs of study and education providers and so are well placed to assess overseas qualifications for the purposes of registration. The Review considers this to be a logical and efficient allocation of responsibilities.

## Independence in the exercise of regulatory powers

Regulation is a mechanism through which government can aim to safeguard the welfare of the community and protect the broader public interest. However, regulators can fail to protect the public interest if their activities are unduly influenced, whether by the regulated parties, government or other interested stakeholders. Most systems internationally and in Australia adopt best practice by conferring independence on the body that administers the regulation.

In 2012, 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:*

- a) there is a need for the regulator to be seen as independent, to maintain public confidence in the objectivity and impartiality of decisions; or*
- b) both government and non-government entities are regulated under the same framework and competitive neutrality is therefore required; or*
- c) the decisions of the regulator can have a significant impact on particular interests and there is a need to protect its impartiality”.* (p16)

Regulation, by its very nature, requires a source of authority. The most appropriate locus of this authority was vigorously debated when setting up the National Scheme in 2010. This reflected a tension between efforts of some professions to maintain a level of self-governance and governments' desire to develop a more independent, actively managed and responsive externally regulated system.

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

*"... 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". (p210)*

## Independence from governments

Any consideration of independence must acknowledge that a regulator's 'independence' from government can never be absolute; rather, it is a matter of degree and nature and it should be clearly articulated – usually through statute. The [Australian National Audit Office](#) (ANAO, p5) depicted the continuum of statutory governance arrangements as follows:

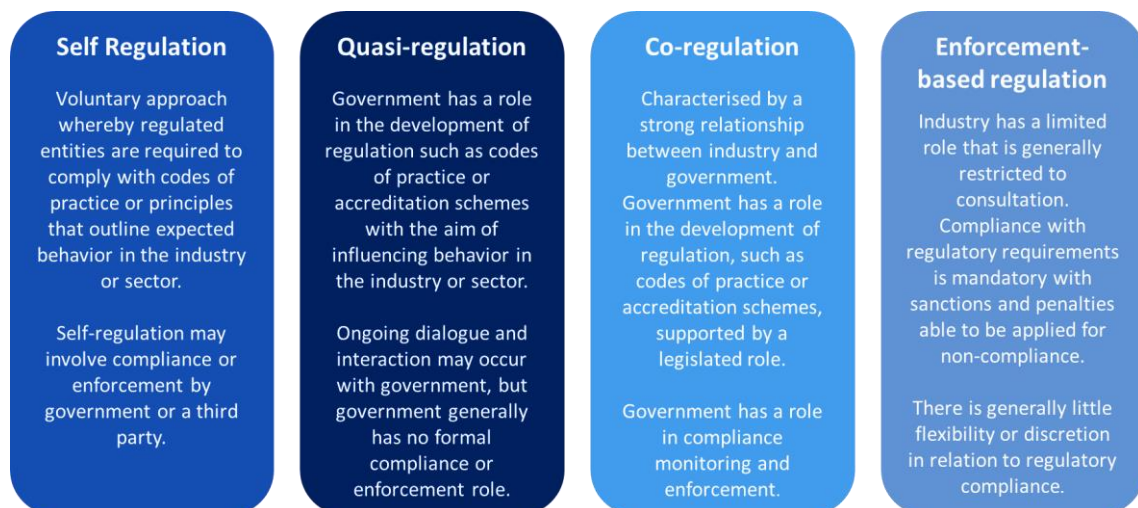


Figure 6.1. Range of regulatory responses

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 in delivering safe, quality patient-centred care. There are many dimensions, multiple stakeholders and far-reaching impacts.

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 and public expenditure are in the public interest. The [World Health Report 2000 - Health Systems: Improving Performance](#) identified stewardship as one of the four key functions for governments in health system management and policy making. The other three are 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 rules ... and 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". (p45)*

The National Law has generally adopted this stewardship concept in that governments have retained some roles in the regulation of health practitioners but have largely established a regulatory regime that is not under direct government 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 where they could impact on the recruitment or supply of health professionals (s11). While some aspects of the National Scheme can be regarded as co-regulatory, the accreditation model equates more to a quasi-regulatory approach on the ANAO continuum.

## Independence from regulated parties and other stakeholders

The governance and accountability arrangements of accreditation authorities should provide that their decisions and activities are objective, impartial, consistent, expert, transparent and in accord with the National Scheme Objectives. Accreditation authorities comprise, at the discretion of the National Boards, committees established by the Boards or external accreditation entities (councils).

Accreditation committees, being creations of the National Boards, have different governance issues to those of councils. As outlined earlier, the appointment (and removal) of the members of the committees is the direct prerogative of the National Boards and this can influence the decisions of the members on those committees. It can reasonably be inferred that the independent exercise of their accreditation function could be compromised on this basis. In addition, AHPRA provides secretariat support, and a degree of policy guidance, to these committees.

Where accreditation councils have been assigned the accreditation function, different questions of independence arise. The overarching principles for their operation were agreed with AHPRA and the National Boards and published as an agreed Quality Framework (see Chapter 2). The Quality Framework establishes a number of governance attributes:

- the external accreditation authority is a legally constituted body, is registered as a business entity and can demonstrate business stability
- the 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 authority's governance arrangements comply with the National Law and other applicable legislative requirements.

The 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.

## Regulatory governance of accreditation functions within external entities

The governance attribute requirements in the Quality Framework mentioned above are largely concerned with the overall management of each accreditation council, whereas the Review is focused on the independence of the subset of accreditation decisions made under the National Scheme. The focus on the conduct of directors is thus not on how the governing boards of accreditation councils conduct their affairs, but rather on the specific responsibilities for the accreditation functions under the National Law.

## The makeup of accreditation councils

The makeup of each council's governing board can be a key factor in its institutional independence and its ability to deliver on the National Scheme objectives and the reform directions in the health system more generally. While the Quality Framework requires a transparent process for selecting the governing body, it is silent on how the membership of the organisation is constructed.

This Review's analysis of annual reports, websites and council constitutions suggests the following:

- Membership is generally limited to specific categories, such as industrial organisations, professional associations, education providers and other representative or umbrella councils, including in some circumstances National Boards themselves. For example:
  - The Australian Nursing and Midwifery Council's constitution states *"There shall be a maximum of five (5) Members of the Company, those being the Australian College of Midwives, Australian College of Nursing, Australian Nursing and Midwifery Federation, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and Council of Deans of Nursing and Midwifery (Australia and New Zealand)"*.
  - Membership of the Optometry Council of Australia and New Zealand (OCANZ) comprises the Accredited Schools acting collectively, the Optometrists Association Australia, the Optometry Board of Australia (OBA), the New Zealand Association of Optometrists and the Optometrists and Dispensing Opticians Board of New Zealand (ODOB). OCANZ's constitution requires its Board to have a Director each nominated by the OBA and ODOB, with further policy on selection criteria determined from time to time by a Nominations Committee elected by OCANZ members.
- The degree of autonomy of the council varies by profession. In psychology, for example, it has only three members - the Psychology Board of Australia, the Australian Psychological Society and the Heads of Departments and Schools of Psychology Australia. Each of the three members is defined as an Appointing Entity and may appoint up to four Directors as its nominees.
- Almost exclusively individuals are either direct nominees of, or elected by, the participating member organisations. It is, however, difficult from public information to identify all board members' affiliations and backgrounds.
- Representatives from education providers and from nominating member organisations are almost always also members of the relevant profession.
- In relation to non-practitioner members, some constitutions specify the processes for making governing board appointments while others are silent. Non-practitioner members appear to be 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.
- The final decisions for each individual accreditation activity are either clearly stated to be the province of the governing board or the decision-making process is unclear.

Part 6 of the National Law does impose some procedural requirements on an accreditation authority that include:

- publishing how it will exercise its accreditation function
- undertaking wide-ranging consultation when developing accreditation standards
- 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 Review considers that statutory decisions made by accreditation authorities, being specifically the accreditation of programs of study, should be protected from the risk of stakeholder capture and that those decisions should be made in an expert and objective manner in the public interest. The Review notes, in this context, that some member organisations of many councils have a material interest in the matters being regulated and can be affected by the decisions that are made.

## The legal constitution of accreditation councils

The Quality Framework requires that an external accreditation authority is a legally constituted body, is registered as a business entity and can demonstrate business stability. Accordingly, accreditation councils are established, in the first instance, under the *Corporations Act 2001*. This Act, together with the *Australian Securities and Investments Commission Act 2001* and various standards or guidelines issued by ASIC or the Australian Charities and Not-for-Profits Commission, however, may not always be consistent with a council's obligations in running a scheme for public benefit.



The Health Professions Accreditation Collaborative Forum (HPACF) submitted a position taken universally by those accreditation councils that have been granted not-for-profit status:

*“Accreditation agencies that are structured as not-for-profit companies are ‘for purpose’ organisations. Their objects as a company relate to one or a set of related purposes such as improving standards of health profession education. Objects of the company are codified in the constitution and company directors have a duty to ensure that the company continues to meet its objects and to ensure that there are systems to check performance against those objects. The Forum considers that this legal framework is sufficient for management of activities that might be construed as commercial (which includes executing accreditation activities under contract), although naturally the Forum is willing to consider proposals that the Review may have in this area”. (DP p20)*

The HPACF further submitted in response to the Draft Report: *“Accreditation authorities are governed by laws and regulations which specifically require them to act in good faith; not to misuse their position; and to disclose perceived or actual material conflicts of interest”. (DR p13)*

Accreditation councils are defined under the National Law as accreditation authorities and exercise statutory duties under s48 of the National Law. This means the exercising of an accreditation function is considered a business of each council as a corporation under the *Corporations Act 2001*. This Act defines a business judgement under s180(3) as *“any decision to take or not take action in respect of a matter relevant to the business operations of the corporation”*. It describes the duties of directors and officers, including care and diligence responsibilities in making business judgements, to include the requirement for both in that Act and at common law that they must *“rationally believe that the judgment is in the best interests of the corporation”* (s180(2)(d)). There is no provision for those decisions to be made, instead, in the best interests of the public.

The Review is not suggesting that any accreditation decisions, or recommendations or advice to National Boards on other accreditation matters have been contrary to the public interest, but a key consideration in this Review has been to propose governance arrangements that future proof the National Scheme and provide governments and stakeholders with confidence that functions are managed appropriately and that the entities within it provide for transparency, accountability and continuous review and improvement. Accordingly, any potential conflict with other legislation is an important area where all potential for doubt should be removed.

This potential is highlighted in the current approach to the application of s236 of the National Law which provides protection from liability for any person (defined to include an individual, body politic or corporate entity) exercising a function under the National Law. Whilst accreditation authorities are covered by this provision, the AHPRA/accreditation council agreement provided to the Review makes no mention of it or how it might be applied. AHPRA, in its response to a question from the Review on this advised *“We consider that section to be clear on the protection from personal liability for members of an external accreditation entity and a person employed or engaged by an external accreditation entity to assist with its accreditation function. There have been verbal discussions with accreditation councils on these provisions”*.

Importantly, a decision by an external accreditation authority not to recommend to a National Board for approval either a program of study or an individual health practitioner as having suitable qualifications for registration is not captured by the specific requirements set in place for other statutory decisions made in the National Scheme, these latter decisions being defined as *“appellable decisions”* to an appropriate responsible tribunal, freedom of information (FOI) or for review by the National Health Practitioner Ombudsman and Privacy Commissioner. The only option available to an aggrieved person or organisation in the circumstances of a decision by an external accreditation authority (or an internal review of its decision) is to seek judicial review.

AHPRA, in its response to the Review, provided no advice on the outcome of discussions with accreditation councils on the application of s236 of the National Law. It would appear, however, that a number of accreditation councils are holding equity to fund responses to potential judicial reviews in relation to their decisions. It is optional for accreditation councils to take up the statutory protections, noting that to do so would also mean that AHPRA would oversight the handling of a response. If an accreditation council determined to respond directly without seeking support under s236 of the National Law, any decisions it made in relation to how it might respond would be then subject to its own determinations and the provisions of corporations law outlined above. Again, this leaves a potential scenario where the public interests under the National Scheme and those of the corporation might not always align.

In addition to legal requirements around such matters as property, rights, and liabilities, many accreditation councils can and do earn income from other sources and are also able to set fees for their services. Councils and their prescribed members can also be involved in various partnerships and international affiliations. All of these factors need to be taken into account in both current operations and any new model of governance.

## Defining the regulatory accreditation functions

Any change in governance arrangements for accreditation needs to recognise and adequately respond to the requirement to maintain the integrity of the National Scheme as a whole. While significant steps have been made to achieve national uniformity in the registration of practitioners in each profession, and AHPRA has made progress on certain aspects of cross-profession commonality, the National Scheme is not yet operating effectively as a single collaborative regime that appoints persons with the necessary expertise to perform particular regulatory functions.

As noted elsewhere in this Report, there are currently two distinct domains of regulatory scope:

- regulation of individual health practitioners
- regulation of accreditation standards, onshore and offshore programs of study and the providers of those programs (including the performance of their governance and operational activities) and the qualifications of overseas trained practitioners.

As outlined earlier in this chapter, the Review concludes that substantial efficiency and effectiveness benefits would accrue through formal and more clearly defined separation of these functions and the development of two distinct areas of regulatory expertise within the single National Scheme, with each having responsibility to meet the National Law objectives. The National Law already acknowledges and apportions various responsibilities to different entities within the National Scheme but requires that they all have regard to the objectives and guiding principles of the Scheme (s4):

***“How functions to be exercised***

*An entity that has functions under this Law is to exercise its functions having regard to the objectives and guiding principles of the national registration and accreditation scheme set out in Section 3”.*

The Review’s preferred approach is to for this separation to apply to the defined set of statutory accreditation functions and for the decisions under those functions to be subject to clear requirements for independence and regulatory scrutiny. The five functions would be:

1. Developing an accreditation standard for approval (see Chapter 7).
2. Approval of programs of study and education providers which meet approved accreditation standards and provide a qualification for the purposes of registration.
3. Approval of any action required as identified in the monitoring of programs of study and providers which meet approved accreditation standards.
4. Approval of authorities in other countries which conduct examinations for registration in a health profession, or accredit programs of study, and approval of those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia.
5. Approval of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession, and advice of the assessment outcome to the relevant National Registration Board.

If there is to be greater independence of the exercise of accreditation functions from those of registration, the Review reaffirms its view that an essential design criterion for new accreditation governance arrangements is that National Boards continue to have trust in the integrity of the accreditation institutions, processes and decisions. The joint National Boards/AHPRA submission to the Draft Report stated: *“Our whole of Scheme view is that governance arrangements must provide all (individuals and entities within and outside the Scheme) with confidence in the expertise of each responsible entity and the integrity and validity of their decisions”.* (DP p11)

That trust would require assurance that successful candidates of accredited programs of study have the knowledge, skills and professional attributes necessary to practise the profession in Australia. The Review has argued earlier in this Report that the optimal way to provide this reassurance is through formalising responsibilities for competency standards with National Boards (Chapter 5). An essential element of accreditation standards is that the curriculum is founded on the competency standards relevant to the individual professions. This would be consistent with the National Boards’ focus on the conduct and practice of individual practitioners in accordance with their competencies, whilst ensuring that the specialised functions of assessing educational programs and providers against standards for the delivery of graduates with those competencies rests with the bodies who are expert in these matters.



## Governance options for the accreditation bodies

The Review is cognisant of the substantial contribution that has been made to accreditation by the current accreditation councils and the critical value they provide through expert professional input. Accordingly, the Review considers that the National Scheme should be largely agnostic to the governance structures of those councils. As private companies, they should also be able to pursue other commercial arrangements provided they are transparent and any conflicts with their National Scheme accreditation functions are managed.

As outlined in this chapter, the Review considers that the management of defined accreditation functions under the National Scheme, and decisions made in relation to those functions, need to:

- place the public interest foremost and provide professional input to decision making based on the expertise of individuals who have knowledge of the professions, professional registration, provision of education, requirements of employers, and the needs and expectations of consumers
- demonstrate decisions are made independently of regulated parties or of other interested stakeholders
- have decisions transparently made and subject to the same grievance and appeals requirements as decisions made by other National Scheme statutory entities
- be able to operate effectively in either an external private entity or under the auspices of the statutory agency, but not have its decisions subject to approval or undue influence by their governing bodies.

An important element for any governance option chosen is that it should not prohibit or discourage the amalgamation of entities carrying out accreditation functions. Some accreditation councils have already chosen to amalgamate some administrative functions and AHPRA provides a consolidated support function to the three accreditation committees. The Review considers there remains opportunities to further improve efficiency and effectiveness and promote consistency in this area, should the various accreditation entities wish to pursue this.

The Draft Report proposed a model that aimed to separate the exercise of accreditation decisions under the National Law from the governance arrangements of external accreditation entities more generally. Specifically, it proposed removing reference to accreditation authorities and redefining accreditation committees under the National Law as being the responsible bodies for exercising the statutory functions. The relevant section of the Draft Report has been republished, with elaboration, as Appendix 7 to this report.

The essential features of the Draft Report proposal were that such an arrangement would enable:

- the identical application of requirements to the three existing accreditation committees and to any similar body hosted by an external entity
- an Accreditation Committee to be appointed within an external entity provided that its statutory decisions are made by a body of experts with the required expertise and not be subject to approval by the Board of Directors of the external entity
- the operational management of the Accreditation Committee function to be by funding agreement between the external entity and AHPRA. The external entity would be responsible for the management of, and support provided to, its decision-making body, including the formation and training of assessment teams, monitoring of performance, reporting on activity and decisions, etc. of the Committee. The agreement would include transparency and public accountability requirements as well as performance measures and outputs and clear pathways for remedial action should any of the requirements or performance measures failing to be met.

Responses to this proposal were mixed, with the key concern being that this would impose an additional level of management and cost in the decision-making structures and that the Accreditation Committees would not be reporting to existing accreditation councils. This is not an accurate representation, as it was envisaged it would report to the accreditation council in terms of its operations, but only that its accreditation decisions would be autonomous. Other complexities arising from this option relate to assigning statutory powers to private organisations and decisions being subject to the same grievance and appeals processes as apply to other National Scheme entities. The Review notes that there are examples in public services that have been privatised where a prescribed set of decisions made by private organisations can be subject to procedural review.

The Review considers that there may be several governance arrangements that achieve the desired outcome. One possibility is to continue with the Accreditation Committee option as described above. Whilst the Review considers most of the concerns could be resolved through a more detailed specification of the proposed model, it does acknowledge that there are several complexities.

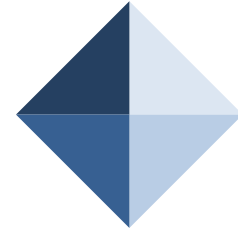
A second option is to retain the statutory responsibilities of accreditation authorities as currently defined under the National Law and the contracting instrument specify that accreditation decisions be made by independent experts in the public interest, and those decisions would be prescribed for the purposes of applying external review and FOI. This model would also need to ensure that there are no conflicts with requirements under the *Corporations Act 2001*, discretion on the application of s236 in dealing with applications for judicial review has been removed and other commercial arrangements an accreditation council might enter into are not captured, provided they are managed separately and transparently, including the management of any conflicts of interest.

The Review has not recommended any one specific governance approach, rather it has focussed on the principles and characteristics a model should have. Should the COAG Health Council choose to adopt the recommendations, it would be expected that expert legal advice would be sought in designing the final governance arrangements and any necessary statutory changes.

## Recommendations

15. Governments should separate responsibility for the regulation of the accreditation functions under the National Law from that of the regulation of individual practitioners. The governing entities of the two functions should operate collaboratively to achieve all objectives of the National Scheme.
16. A health profession accreditation body for each regulated profession (being the current accreditation authority for at least the first five years) is to be assigned to undertake the accreditation functions described in s42 of the National Law as amended as follows:
  - a. Development of accreditation standards for approval (see Recommendation 19)
  - b. Approval of programs of study and education providers which meet approved accreditation standards and provide a qualification for the purposes of registration
  - c. Approval of any action required as identified in the monitoring of programs of study and providers which meet approved accreditation standards
  - d. Approval of authorities in other countries which conduct examinations for registration in a health profession, or accredit programs of study and approval of those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia
  - e. Approval of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession, and advice of the assessment outcome to the relevant National Board.
17. The governance of a health profession accreditation body should be structured to ensure the body achieves the following in the accreditation of health profession education:
  - a. It must place the public interest foremost and apply professional and other expert input to decision-making that is in accordance with National Scheme objectives
  - b. It exercises its decision-making independently of regulated parties and other interested stakeholders
  - c. Its decisions should be transparent and subject to the same grievance and appeals requirements as decisions made by other National Scheme entities (as described in Recommendation 31)
  - d. The governance structure of an accreditation body must enable it to operate effectively in either an external private entity or under the auspices of AHPRA, the statutory agency, but not have its decisions subject to approval or undue influence by their governing bodies.
18. Governance arrangements must be designed to be able to support potential future amalgamation of health profession accreditation bodies for efficiency and effectiveness purposes should such amalgamation be agreed.

## 7 A governance model for more efficient and effective accreditation



Following the establishment of four key design criteria for a health education accreditation regulatory model and underpinning role of accreditation and its relationship to registration in Chapter 6, this chapter explores options for a governance model for accreditation across the National Scheme as a whole that will best support achievement of the National Law objectives.

### Key messages

The role of education and its accreditation is to provide a foundation of knowledge, skills and professional attributes for the health workforce which would enable it to deliver safe, high quality care in an innovative, flexible, responsive and sustainable manner.

The National Scheme should not itself become a silo by only focussing on the education and practice of the individual registered health professions – it must adopt a more collaborative, outward and future-oriented perspective.

The maturity of national education regulatory schemes and health safety and quality systems has provided new opportunities for removing unnecessary duplication of regulation and for more efficient delivery of functions based on regulatory expertise and consistency across both health and education.

A more defined governance approach should enable all National Scheme entities to proportionately and transparently balance all National Law objectives according to their functions, comply with all National Law guiding principles and have trust in the integrity and expertise of all decisions made by each responsible entity.

To only propose the separation of profession-specific accreditation functions from that of regulation, without further changes to the governance model, could perpetuate the largely professionally siloed approach to setting standards, undertaking assessments and influencing curriculum development and delivery.

Accreditation governance arrangements should be structured to provide authority to progress the reform proposals in a manner that transcends individual health professions while ensuring the input of profession-specific expertise where necessary. Accordingly, there is a need to establish an integrative oversight body to lead cross-professional matters.

A separate national health education accreditation body is the preferred model, but in the context of governance simplicity and alignment with any broader NRAS governance reform, the Review is not averse to expanding the role of the AManC to take on these functions.

### Supporting the National Scheme objectives

In the 2008 intergovernmental agreement, COAG specified the objectives (and guiding principles) for the National Scheme as now reflected in the National Law (s3). The Review considers that they should be addressed in a balanced manner and responded to in the policy framework adopted for the National Scheme as a whole and in individual decisions taken by Scheme entities.

The [AHPRA Corporate Plan 2011–2014](#) stated that its vision was to achieve “A competent and flexible health workforce that meets the current and future needs of the Australian community”. It is acknowledged, however, that in the initial set up period the focus was primarily on establishing the National Scheme and its systems. While AHPRA does not have a current corporate plan, its [National Registration and Accreditation Scheme Strategy 2015–20](#) broadly provides the same vision and includes the following statement in its strategic outcomes “Improved access to healthcare through our contribution to a more sustainable health workforce”. Further, AHPRA and the National Boards developed a set of principles in 2014 with the stated intent being to shape the thinking about their regulatory decision making. One of the principles in the Strategy is that “While we balance all the objectives of the National Registration and Accreditation Scheme, our primary consideration is to protect the public”.

The Review agrees that a person’s health is the paramount consideration. However, while that consideration includes the protection of the public, it also includes ensuring that people have access to practitioners who have high quality education and to services and practitioners where they are needed, and to those services being innovative and delivered by a flexible, responsive and sustainable health workforce. In short, all objectives are relevant. The Review would be concerned if considerations of safety and quality were being inappropriately invoked to resist beneficial innovation in models of care, scopes of practice or the design of the financial and other incentives embedded in the health system.

### The contribution of accreditation entities

To assist in the Review’s examination of how the accreditation system has contributed to achieving National Scheme objectives, it has examined the publicly available AHPRA business plans (2012–13 to 2015–16), its 2011–2014 Corporate Plan and, to the extent that they have been made available to the Review, performance reports and budget proposals and agreements between National Boards and accreditation entities since the National Scheme was established.

In the case of the three accreditation committees, their operational independence in supporting the National Scheme objectives could be compromised Committee members are appointed (and reappointed or not) by their Boards. Further, in correspondence to the Review, AHPRA advised:

*“The (AHPRA) Accreditation Unit, in consultation with each Committee, develops the proposed budget and workplan. ... Each Board that exercises the accreditation functions through a committee pays an allocation to AHPRA to provide support for delivery of accreditation functions under the Health Professions Agreement.... Income from fees paid by education providers is treated as Board income and all expenses are treated as Board expenses. This means any variation against budget is attributed to the Board. In this way, only the amount of registrant fees required to break even is required for the relevant Accreditation Committee’s activities”.*

The relationship between each National Board, AHPRA and accreditation councils is of a different nature. It is managed through a standard funding agreement with AHPRA, supported by profession-specific schedules outlining deliverables and reporting requirements. Accreditation councils are required to report on some indicators twice yearly and provide a comprehensive report annually. There is a standard clause in each 2015–16 agreement, as follows:

*“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):*

- a) 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;*
- b) opportunities for the Council to facilitate and support inter-professional learning in its work; and*
- c) 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”.*

Such a clause, while acknowledging key reform priorities, is relatively passive and stops short of setting specific reform targets for councils. This is echoed in the content of budget proposals, approvals and performance plans. AHPRA advised that it funded a project officer to work on the Accreditation Liaison Group (ALG) Costing Paper and international benchmarking; however, no further detail has been provided and the Review has not identified any other instances of funding being sought or approved for cross-profession or other innovation initiatives. The Health Professions Accreditation Collaborative Forum (HPACF) also advised that it has not received funding to undertake any of its activities or to progress broader reform priorities.

This absence of more active strategic planning and implementation is a concern. Many of the improvements in system efficiency and effectiveness proposed in this Report are not new discoveries. They can be found in previous reviews, the deliberations of the HPACF and submissions to this Review. It is a poor use of time and resources to conduct periodic reviews to identify what is generally known and agreed, but not yet implemented. Many stakeholders, including the National Boards, AHPRA and governments, acknowledge that progress has been sub-optimal and more integrative approaches are needed (Box 7.1). In the Review's judgement, the greatest constraint to the development of a more efficient and effective accreditation system, and to more relevant and responsive health profession education, is the inadequacy of the model of governance.

#### Box 7.1 Views on reform progress

##### **Joint National Boards/AHPRA**

*We recognise that more can be done in terms of the potential of accreditation to contribute to the Scheme as a whole. In addition, we are committed to adopting more risk and evidence based policy and processes supported by good evaluation and research. (DP p2)*

##### **AHPRA Agency Management Committee (supplementary submission)**

*AManC considers that while reasonable progress has been made by National Boards and AHPRA to support flexibility and sustainability of the health workforce, the governance of accreditation systems that transitioned into the National Scheme in 2010 has contributed to slower progress of some initiatives. These transition arrangements do not reflect the maturation of the National Scheme since 2010. (DP p4)*

##### **Department of Health and Human Services Victoria**

*The future health workforce will be required to work across professions, within integrated services, in new and flexible roles, delivering person-centred care. The current profession-led accreditation system, with 14 accreditation councils or committees, maintains a profession focus which presents challenges in developing the future workforce. (DP p8)*

##### **Commonwealth Department of Health**

*A more integrated accreditation system would support the education sector to produce a health workforce that is designed to meet the future needs of the Australian community, and will encourage a system that produces a health workforce that is responsive to new and innovative models of care. (DP p3)*

##### **NSW Health**

*The current system of single profession specific accreditation authorities is hampering equality of professionalism in accreditation and cross-disciplinary education. The current system perpetuates: duplication of work both by accrediting authorities and education providers; lack of an overall health policy focus in relation to education provision; interests of each profession over wider community interests and the objectives of the NRAS; and fragmented consideration of workforce requirements. (DP p1)*

The reforms to accreditation bodies that have been proposed in Chapter 6 would create a degree of functional separation which would recognise the different scope of expertise required for developing accreditation standards and accrediting programs of study compared to regulating the registration of individual health practitioners. However, to only propose the separation of these functions, without further changes to the governance model, could perpetuate the current siloed approach.

Accordingly, the Review has also explored a second level of reforms which would lead to a more integrated approach to the accreditation of health profession education and to a more active support for the National Scheme objectives. This exploration starts with an examination of alternative governance regimes.

## Regulation of health professionals – lessons from overseas

The Review has looked to the regulatory systems of other countries for guidance. Of particular relevance is the Health and Care Professions Council (HCPC) in the UK, which has been set up as a regulator of 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 does not regulate nursing, medicine, pharmacy, dental or several other health professions that are registered professions under our National Scheme, but those professions do come under the purview of the Professional Standards Authority (PSA) (see below). 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. It has one set of standards for education and training that apply across all the professions it regulates, covering the level of qualification, program admissions, program management and resources, curriculum, practice placements and assessment. Benefits include consistent expectations for interprofessional education and for consumer and carer involvement. The HCPC also provides a single and consistent approach to assessing and accrediting education programs against those standards of proficiency through its Education and Training Committee, which has been given statutory responsibility for this function.

In terms of the applicability of such an integrated model in Australia, the Australian Medical Council (AMC), Australian Pharmacy Council (APC) and the HPACF all referred to the 2015 decision by the UK Government to move the regulation of social workers from the HCPC and to create a separate entity, as evidence that a joined-up accreditation approach is not fit for purpose.

While recognising that Australia does not regulate social workers, the Review notes that the decision was preceded by a long period of [calls for reform](#) to the social work system, a number of high profile protection issues arising in residential and other services for children, various reports into the fragmentation of social work education in the UK, and the financial collapse of the College of Social Work. The UK Government's response has included the passing of the Children and Social Work Act 2017 and the announcement of a new body, Social Work England, to be created to oversee and regulate a range of matters relating to social work and the delivery of social care services. The remit of the organisation is planned to be broad ranging and different to all other profession regulatory bodies. It would seem the resulting regulatory model for social work does not reflect on the capability of the HCPC as an integrated regulator of health professions.

While the HCPC does not cover many of the professions under the National Scheme, the umbrella authority to which it reports, the PSA, oversees nine regulators who 'register' health and care professionals working in occupations nominated by Parliament. The PSA is responsible for overseeing the HCPC as well as the: General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing & Midwifery Council and 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.

The PSA has been undertaking research focused on the UK health and social care professions regulatory framework. The 2016 report, [Regulation Rethought - Proposals for Reform](#) made findings on difficulties facing educators in supporting innovation in service delivery. They resonate with those of this Review:

*“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”. (p1)*



The PSA report outlines 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:

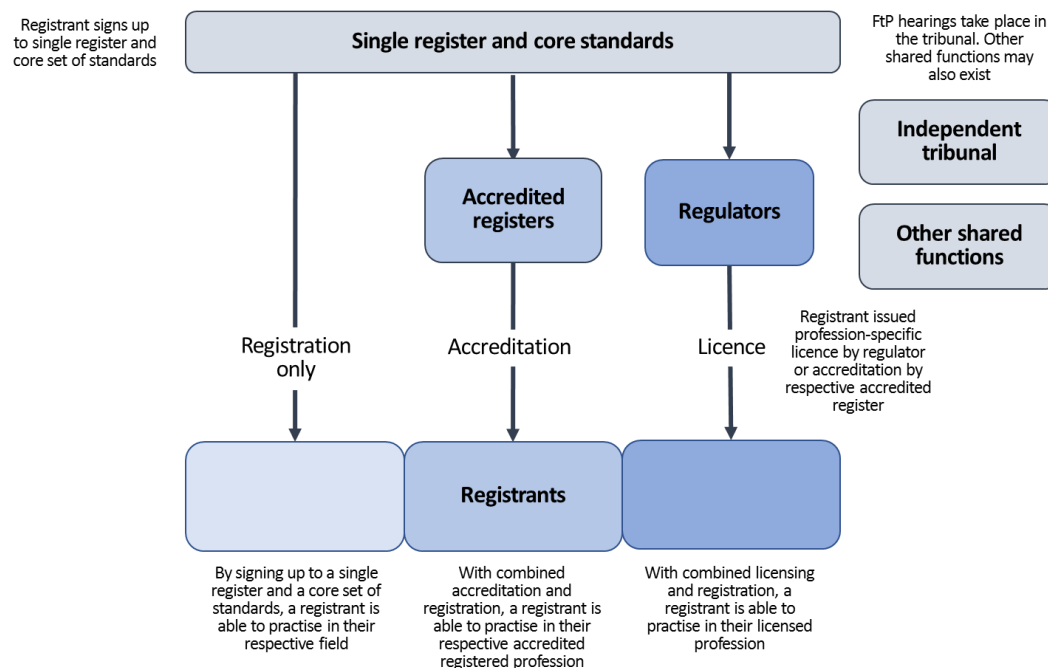


Figure: 7.1 PSA's single assurance body

Some of the many benefits the PSA sees in the Australian 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 whom 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 which sought to promote beneficial cross-profession job evolution and redesign, interdisciplinary and multidisciplinary education, more appropriate and consistent accreditation and reduced administrative and compliance costs. The overall concept is beyond the Terms of Reference of this Review, but the UK report does provide valuable insight into similar issues being explored around the accreditation of education.

The UK and Australia share experiences in the development of more integrated education and regulatory arrangements. In 2014, the British, Scottish and Northern Ireland Law Commissions jointly released their review report into the *Regulation of Health Care Professionals and Regulation of Social Care Professionals (in England only)*, along with a draft Bill. Of particular relevance to this Review was the proposal put forward by the [Scottish Government](#) around the need for system integration:

*"The new statute could provide further clarity and consistency by coordinating their activities through one central body with representation from individual regulators as required (i.e. a 'hub and spoke' model). This would provide greater consistency in standards and a more coordinated approach to quality assurance and inspections, and provide opportunities for shared learning and decision-making including, for example, in relation to multi-disciplinary/multi-professional education and training". (p2)*



The [Commissions](#)’ acknowledged the need for flexibility and further consideration of this concept:

*“Suggestions made by the Scottish Government for the establishment of a new central body to co-ordinate activity in these areas and a combined code of conduct are interesting. At this point, there are no concrete plans to take these suggestions forward. However, the draft Bill would certainly not preclude the establishment of such a body or the development of joint codes and indeed would facilitate these through partnership arrangements [see Part 10]”. (p94)*

## Improved integration with the safety and quality regime

Since the establishment of the National Scheme in 2010, other significant national reforms in education (discussed in Chapter 2) and health have been implemented that provide unique opportunities for improved regulatory administration not previously available:

- The maturity of national regulatory schemes in higher and vocational education has provided opportunities for the removal of unnecessary duplication of regulation and for more efficient delivery of functions based on expertise and consistency across both health and education.
- Alignment of workforce education and accreditation with national developments in safety and quality in health care can similarly provide an opportunity to progress a whole-of-health system approach. Significant reform has been undertaken in the regulation of safety and quality across the health system.

ACSQHC was established in 2006 by the Commonwealth, state and territory governments to lead and coordinate national improvements in this area and in 2011, the *National Health Reform Act 2011* established ACSQHC as an independent statutory authority.

To drive the implementation of safety and quality systems and improve the quality of health care in Australia, ACSQHC developed the National Safety and Quality Health Service (NSQHS) Standards to be managed through a national accreditation model, the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. In September 2011, Health Ministers endorsed the NSQHS Standards and the AHSSQA Scheme.

From a governance perspective, the AHSSQA Scheme contains some similar elements to the National Scheme approach, with ACSQHC being an umbrella organisation that:

- develops and maintains the NSQHS Standards
- undertakes ongoing liaison with state and territory health departments on opportunities to improve the standards and the accreditation system
- approves expert accrediting agencies that assess health service organisations against the standards
- 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 approving any expert accrediting agency is that it must hold current organisational accreditation with an internationally recognised body. ACSQHC quotes as examples the International Society for Quality in Healthcare and the Joint Accreditation System of Australia and New Zealand. 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 ACSQHC’s overall role is its focus on continuous improvement in the nature and currency of the standards, assessment mechanisms and overall performance of the scheme. A second major focus is on credentialing – 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 practise within the bounds of their training and competency, and within the capacity of the service in which they are working. Equally, it can ensure more efficient utilisation of the workforce by permitting clinicians to practise to the full scope of their training and competency. 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.

ACSQHC advises that implementation of the national standard is underway in all jurisdictions and across the private hospital sector, with the structures and processes being used varying 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.

ACSQHC [Strategic Plan 2014–2019](#) includes, as measures of success, whether safety and quality are considered as important aspects of undergraduate and postgraduate curricula for health professionals. To this end, ACSQHC has discussed with education providers the need to address the NSQHS Standards in curriculum for all health professions, both within and outside the National Scheme. The Review strongly supports the integration of a safety and quality focus as fundamental to health practitioner education into the National Scheme through the work of the ACSQHC.

## Options for governance reform

Evidence and analysis set out earlier in this report have identified the governance arrangements within the National Scheme, and across other relevant regulatory regimes, as a set of overlapping functions and powers. These arrangements can result in inefficiency, reduced transparency and a lack of accountability for reforms that would be in the public interest. This is evident from the following depiction of the current ‘systems’.

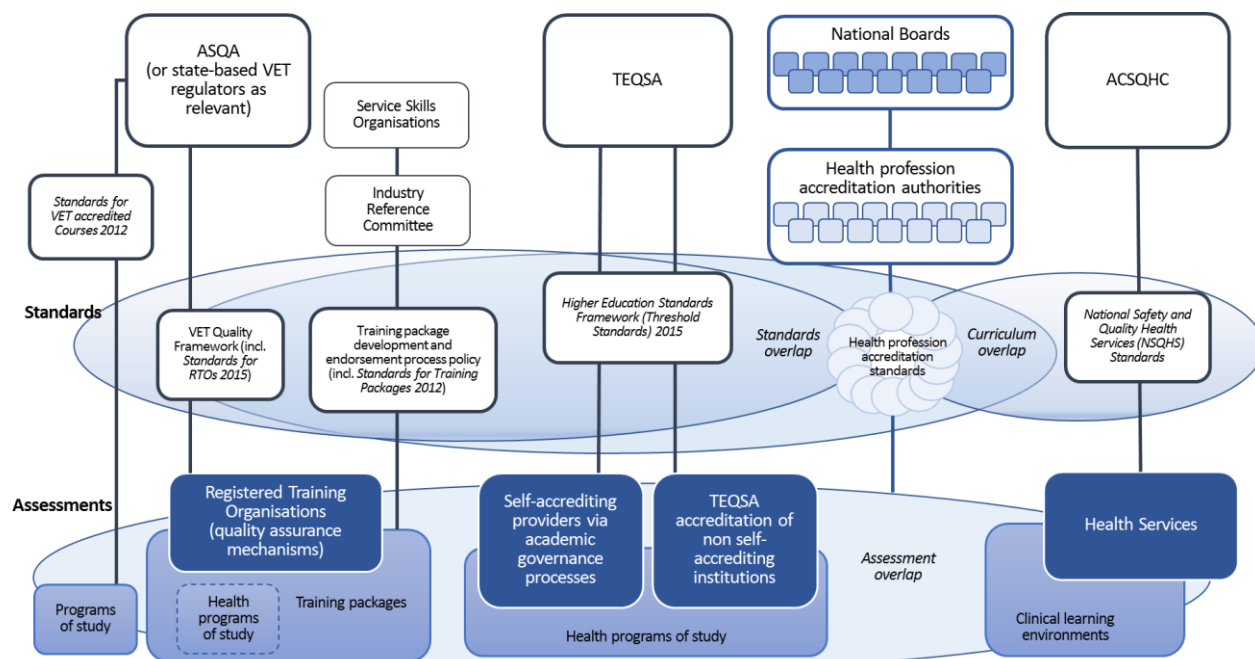


Figure 7.2 The current health and education accreditation systems

Reform of accreditation governance can help simplify this complex array of entities and functions through:

- establishing greater separation between the registration of practitioners and the accreditation of health profession education, based on their respective expertise
- creating a more integrated, efficient and effective cross-profession accreditation regime within the National Scheme
- removing unnecessary overlaps between the National Scheme and other accreditation regimes.

## Governance reform goals

As the basis for determining the most appropriate governance arrangements for the accreditation function, the Review has identified four broad goals that reforms should target:

- Planning for the future workforce must be embedded within overall health system reform priorities. The role of education and its accreditation is to provide a foundation for a workforce that is more flexible, responsive and sustainable and that enables innovative improvement in service delivery.

- Health services and the education of the workforce that delivers those services must be developed to foster collaboration between health care and related social and other services in responding to community needs. The delivery of such integrated service responses is aimed at having a greater client focus, improving health and wellbeing, assisting individuals and households with multiple and complex health and social needs and making cost-effective use of technological innovations.
- Joined up service delivery needs to connect many professions both within and outside the remit of the National Scheme. While there are important additional requirements and standards that registered health practitioners are required to meet, the various National Scheme functions should not become a silo by virtue of only considering the education and practice of the registered health professions.
- The regulation of health professionals must better link into related national systems and initiatives within health and beyond. The functions of the regulators frequently cross organisational and legal boundaries and the same or similar function is often undertaken by different organisations.

## Criteria for the design of the regulatory regime

In progressing these goals, the Review has identified in both Chapter 6 and Chapter 7 a set of criteria to guide the design of the regulatory reforms which are summarised for completeness here:

- NRAS is a single National Scheme with a number of component regulatory responsibilities and accountabilities for decisions that should be applied to all scheme entities. Multivariable controllers need to be established that can regulate a number of distinct elements.
- It is the responsibility of all National Scheme entities to proportionately and transparently balance all National Law objectives according to their functions, and comply with all National Law guiding principles.
- Governance arrangements must provide a framework for all decision-making entities in the National Scheme to have trust in the integrity and expertise of all decisions made by each responsible entity. Decisions on standards, policies and individual assessments of programs of study must be made in an objective manner in the public interest.
- Duplication of the supervisory and decision-making functions of regulators should be avoided and where there are more competent regulatory authorities (both within and external to the National Scheme) they should be used to ensure an integrated, consistent and efficient regulatory framework.
- As far as is practicable, the principles of good regulatory practice of separating the standard setting function from the function of assessing compliance against those standards should be adopted.
- Governance arrangements should operate with the minimum necessary costs and administrative burden. Entities should administer a principles-based regulatory framework in a way that minimises compliance costs, provides stability, and is efficient, effective and transparent.
- The accreditation governance arrangements should be structured to:
  - provide authority to progress the reform proposals in this report in a manner that transcends individual professions while ensuring the input of professional expertise where necessary
  - provide governments, stakeholders and the community with confidence that the arrangements will deliver continuous improvement of the standards, assessment processes and overall performance of the accreditation system and its component entities, ensuring that regulatory administration remains relevant and effective over time.

## Responses to the Draft Report governance proposals

Most stakeholders agree that reforms are possible, progress has been sub-optimal, and more integrative approaches are necessary. However, submissions to the Review have proposed solutions ranging from making minor enhancements to the status quo to more substantive governance change. When preparing the Draft Report, the Review developed three options, drawn from submissions and its own analysis:

- The first option largely reflected the approach proposed by the HPACF and by the National Boards/AHPRA in their joint submission to the Discussion Paper. This option was to adopt a more rigorous approach to the use of cross-profession advisory committees and the creation of additional advisory committees on particular issues.

- The second option was based on the proposal put forward by the AManC/AHPRA in its supplementary submission to the Review. This option suggested some change and expansion to the role of AManC, but largely retained the separate accreditation powers of the 14 profession-specific National Boards.
- The third option was a governance model that separated the regulation of accreditation from that of registration. It proposed a national cross-profession accreditation framework for health profession education and training within the National Scheme structure. The proposal was for a statutory board with a secretariat drawn from AHPRA, to sit alongside the National Registration Boards.

There was limited response to the first option. In its submission to the Draft Report, however, the HPACF developed the option further, and this has formed the basis of Option 1 in this final Report. The details are set out in the next section.

The second option received almost no support and the joint submission by AHPRA and the National Boards to the Draft Report moved away from it and instead proposed a new option. The joint submission can be found on AHPRA's page or with all other submissions on the COAG Health Council's [website](#). The proposal is similar to the third option in the Draft Report with two key exceptions:

- Firstly, it proposes *"...that an accredited program is approved as providing a qualification for registration purposes on receipt of a report on accreditation unless the National Board has, on the basis of a notice from the accreditation authority, or for any other reason, legitimate concerns about the capacity of graduates to practise safely"*. (DR p11)
- Whilst the submission does not specify the options available to a National Board in that circumstance, it can be assumed that it would comprise the existing legislated options to either not approve an accreditation decision or subsequently place conditions on the program of study in terms of the graduate's registration status as provided under National Law s49 and s52. By suggesting that the basis of exercising such a power would be either advice from the accreditation authority, or *"for any other reason"*, it is clear that effective authority over accreditation would continue to rest with National Boards and thus maintain the status quo.
- The question of where decision making powers should rest in relation to approving programs of study is dealt with in detail in Chapter 6. It is acknowledged that, in providing clear autonomy to accreditation authorities in accrediting programs of study, one of the essential design criteria for new accreditation governance arrangements is that National Boards continue to have trust in the integrity of the accreditation institutions and processes, while no longer having powers of approval of accreditation standards, programs of study and education providers. How that might be achieved is outlined later in this chapter.
- Secondly, the AHPRA/National Boards option proposes that the overarching, cross-professional accreditation functions be undertaken by the AManC through it establishing an expert accreditation committee, rather than by a separate body. This possibility was specifically canvassed in the Draft Report to seek stakeholder views and the Review considers that it is a potential configuration in its consideration of a more integrated approach.

In this Final Report, the Review has adopted a three-stage approach to the analysis of options. In the first instance, the Review has assessed the relative merits of adopting a more rigorous approach to the use of cross-profession advisory committees (Option 1) compared to establishing an accreditation entity which would sit alongside National Registration Boards (Option 2). The second stage of analysis is an assessment of whether that body should be an expert committee of the AManC or a separate body. The third element of the assessment is to consider costs across all of the three possible configurations.

## Stage 1 analysis: comparative assessment of an interprofessional committee (Option 1) and a cross-profession accreditation governance body (Option 2).

### *Option 1 - Enhance an existing forum or liaison committee*

The Review's final Report Option 1, similar to that set out in the Draft Report, is to enhance the role of an existing forum or liaison committee and strengthen other existing governance processes to streamline what the National Boards/AHPRA have referred to as the time-consuming and resource-intensive nature of the current arrangements.

The joint National Boards/AHPRA submission to the Discussion Paper asked whether it was possible to streamline the current governance arrangements:

*“... current governance arrangements involve 29 different entities (including statutory authorities and not for profit companies) within NRAS that make decisions and perform activities related to accreditation. As a result, there is significant reliance on goodwill and consensus approaches, which can be time consuming and resource intensive. The question is whether it is possible to streamline governance arrangements to increase the effectiveness of the accreditation functions, and which model will best do this”. (p13)*

The Draft Report has noted the important contributions of the HPACF and the ALG and assessed whether either body could assume this more formal role with dedicated funding and an expanded membership, including additional representatives from consumers, education providers and possibly jurisdictions.

In its submission to the Draft Report, the HPACF provided a proposal on how to enhance the existing collaborative arrangements, including an interprofessional oversight committee and a properly funded collaborative forum:

*“When the Review’s reform objectives are considered apart from the governance recommendations of the Draft Report, the Forum considers that these can be achieved more effectively and at significantly less cost by:*

- o a committee to oversight interprofessional issues with representation from national boards, accreditation authorities, and AHPRA, as well as consumer representatives and education providers*
- o a group such as the Forum to coordinate interprofessional work, but with proper funding*
- o more robust performance requirements in current contracts with accreditation authorities*
- o Ministerial endorsement of selected non-governance recommendations in the Draft Report, and*
- o clearer government direction on accreditation and workforce matters, also recommended in the Draft Report.*

*Clearly, thought needs to be given to the terms of reference and the powers granted to the group mentioned in the first dot point above”. (DR p15)*

The Review welcomes the consideration that the HPACF has put into its proposal and notes that it includes important elements critical to any well-functioning model.

There was a limited number of submissions in favour of the first option as proposed in the Draft Report, with the majority of those coming from professional organisations. Submissions also canvassed the need to implement governance changes and add resources to put such an approach in place.

#### Box 7.2 An enhanced role for an existing forum

##### **Australian Medical Association**

*To the extent that greater collaboration is needed between accreditation bodies on matters such as accreditation processes and inter-professional learning, then this is something that could easily be facilitated through the existing Health Professions Accreditation Collaborative Forum (HPACF). We note that that the HPACF operates with almost no resources and, to this extent, will require additional support if it is to undertake this role effectively.*

*The AMA does not support a structure which seeks to increase the role of government in setting the standards, policies and procedures affecting the education and training of Australia’s medical profession. (DR p3)*

##### **Australian Dental Association**

*There may be a role for Option 1 to be enhanced through the role of an existing forum or liaison committee. Option 1, envisaging a cross-professional advisory body to provide advice on common approaches to accreditation standards and processes, and develop reference and guidance documents to promote principles of consistency, efficiency and transparency is reasonable. Health Professions Accreditation Collaborative Forum (HPACF) or the AHPRA Accreditation Liaison Group (ALG) could assume this more formalised role with membership expanded with additional representatives from consumers, education providers and jurisdictions. (DR p16)*

## Box 7.2 An enhanced role for an existing forum

**Occupational Therapy Council**

*OTC supports deeper consideration of Option 1, namely leaving the existing structure and system in place and providing more resources to the National Boards and HPACF to enable the timeframes to be reduced. While the Report is critical of the lack of progress made by HPACF in the past on many of the issues raised, this has been due to lack of funding for HPACF. (DR p7)*

**Northern Territory Department of Health**

*The Northern Territory supports Option 1 as the best way to reform governance of NRAS accreditation systems with minimal cost and impact on registrants and the National Scheme in general. The Health Professions Accreditation Collaborative Forum or the AHPRA Accreditation Liaison Group should be formalised in a timely manner and membership adjusted as required. (DR p9)*

**Pharmacy Board of Australia**

*The Pharmacy Board of Australia proposes a strengthened option 1 in which a governance committee is formally constituted, comprising members from accreditation councils (which have the necessary accreditation expertise) national boards; education providers; health service providers; consumers; and AHPRA. This could be achieved through legislative or policy change or by direction of the Ministerial Council. This option would deliver the outcomes that the independent reviewer is seeking for the accreditation system with minimal disruption and no additional bureaucracy. It would also maintain and maximise existing structures, expertise and working relationships. (DR p10)*

*Impact assessment of Option 1*

The Review has analysed the performance of the current accreditation bodies in the National Scheme, including the performance of non-formal collaborative committees, and the resultant progress with reforms within the limits of the information made available.

The accreditation authorities, with the support of AHPRA, have sought to improve approaches to cross-profession and interprofessional accreditation through the establishment of the HPACF in 2007. The HPACF's [stated purpose](#) (as provided on its website) is for the accreditation authorities:

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

Even though the HPACF is a longstanding body, it was not until March 2017 that the accreditation committees for Aboriginal and Torres Strait Islander health practice, Chinese medicine and medical radiation practice were invited by HPACF to become members, with HPACF renaming itself a “collaborative” forum. As a system-level collaborative model, HPACF has proven to be a valuable initiative and has achieved a number of improvements to the accreditation system. As noted earlier, HPACF has issued several position statements on matters relating to accreditation functions and advises that it meets annually with all National Boards and AHPRA to discuss how to build effectiveness in the National Scheme, particularly in relation to accreditation. Further evidence of the HPACF acting as an enabling forum, for example, has been the progressive roll-out of the Australian Dental Council's Accreditation Standards ‘template’ to many other accreditation authorities.

As a separate initiative, in 2012, the ALG was established as a subcommittee of the Forum of NRAS Chairs. It comprises representatives of National Boards, accreditation authorities and AHPRA and advises on common accreditation issues. AHPRA has advised in correspondence to the Review that the ALG:

*“... is an advisory group which has developed a number of reference documents to promote consistency and good practice in accreditation while taking into account the variation across entities. These documents have been approved by National Boards and Accreditation Authorities”.*



The ALG receives project and administrative support from AHPRA. The ALG was initially proposed by HPACF in its submission to the Discussion Paper as the entity that could be enhanced to provide cross-profession consideration of accreditation issues:

*“... one potential solution to the challenge of carrying out the accreditation functions provided in the National Law while progressing cross-profession issues is a coordination group building on the existing Accreditation Liaison Group, giving that group enhanced remit and expanded membership. It would need representation from all three major types of organisations within accreditation roles in NRAS: National Boards; accreditation authorities; and AHPRA, as well as community representatives, education providers and possibly also policy advisors”. (DP p21)*

As indicated earlier, the Review has examined the various governance arrangements that can be employed to drive efficiency and effectiveness improvements and create more relevant and responsive health profession education. It has worked through the various funding agreements, performance reports and governance arrangements but has been unable to identify any references that indicate a structured focus on resolving longstanding issues that are well understood and agreed to in principle both within and across professions. The Review notes that these opportunities to drive reform have been available within the National Scheme since its inception, but their limited use adds weight to concerns about essentially maintaining the status quo.

The issue of prescribing rights by health practitioners is a case in point. In 2012, Health Workforce Australia (HWA) commenced a 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 to enable health practitioners other than medical practitioners to prescribe medicines consistent with their scope of professional practice. It has taken more than four years to reach agreement between stakeholders and the issuing of an AHMAC [Guidance Note](#) in December 2016 on how individual National Boards may apply to the Ministerial Council for approval of the terms of a new scheduled medicines endorsement or amendment. The application process remains profession specific and lengthy.

In an ideal regulatory model, any decisions made within the National Scheme in relation to prescribing would be agnostic to professional boundaries and would focus on whether the programs of study provide the necessary competencies to undertake safe prescribing. Decisions as to whether this capability could become practice are separate approval matters that currently remain the province of jurisdictions.

A second example is the development of closer collaboration with TEQSA. The Australian Dental Council (ADC) established an MoU with TEQSA for information sharing in November 2014 and the AMC followed in July 2016. TEQSA has subsequently reported greater interest by accreditation councils in such arrangements and information-sharing MoUs having now been signed with Speech Pathology Australia (December 2016), Australasian Osteopathic Accreditation Council (February 2017), Australian Nursing and Midwifery Accreditation Council (February 2017), Australian Pharmacy Council (April 2017) and the Optometry Council of Australian and New Zealand (August 2017). TEQSA has also advised, however, that steps have yet to be taken by any of the councils to implement the MoUs. The ADC, which has the longest standing MoU (2014), stated in its submission to the Discussion Paper that *“... discussions have commenced regarding the routine sharing of data and information between TEQSA and the ADC to inform risk based decisions”*. (DP p21)

The HPACF has recently developed a forward action plan and provided a copy to the Review in November 2017. This is a welcome development, however, the Review notes that the projected outcomes of the work program remain subject to the voluntary nature of the alliance. It is still up to the 14 accreditation authorities to take their own actions, and then critically, where relevant, those actions may be subject to decisions of the 14 National Boards under the National Law.

The Review also sought further details on how work and priorities of the ALG are determined, along with resourcing requirements. AHPRA advised in direct response to the Review on 17 November 2017:

*“The ALG’s workplan comprises high level annually agreed broad areas of work and agreed priorities. The workplan reflects the collaborative nature and non-decision making status of the ALG. It is not presented formally or developed as a multiyear program, however it comprises consideration of the annual workplan and funding cycle for external accreditation authorities and the development and publication of the multi profession accreditation resources published on the AHPRA website and referenced in the ASR draft report”*.

This affirmation of the non-decision-making status of a body that addresses high level and broad areas of work that is not presented formally nor developed as a multiyear program reinforces the Review’s assessment that, in terms of the likely overall impact of this option, the ALG, even in an enhanced form, would not be an optimal solution for delivering reform.



The Review concludes that both the HPACF and the ALG have fundamental limitations. They are not determinative bodies and cannot drive the necessary reforms to a timely conclusion. The functions have no mechanism to bring common matters together at decision-making points because the accreditation system and the National Scheme remain subject to individual decisions for the 14 regulated professions, either at an accreditation authority level or National Board level. This lack of a cross-profession locus of authority also puts at risk the collective reform of relationships and assignment of responsibilities with TEQSA and ASQA, and with ACSQHC on matters such as safety and quality in competencies and curriculum.

Accordingly, the Review does not consider that there would be significant reform benefits under Option 1. However, irrespective of the future governance of accreditation functions, the Review recognises the important role that the HPACF plays in bringing together accreditation entities to enhance cooperation and progress common issues, and the role of the ALG in providing a forum for accreditation authorities and National Boards to pursue common interests. Continued collaboration will be critical, as will a structured work program and the provision of substantive resources to action the program.

*Option 2 - Establish a national health education accreditation body*

The Review’s Final Report Option 2 is to establish a statutory national health education accreditation body within the National Scheme, with secretariat and policy capability drawn from AHPRA, to sit alongside the National Registration Boards. As examined under the following Stage 2 analysis, this body could be either an expert committee of the AManC or a separate national health education accreditation body. Overall function responsibilities and relationships are depicted in the following:

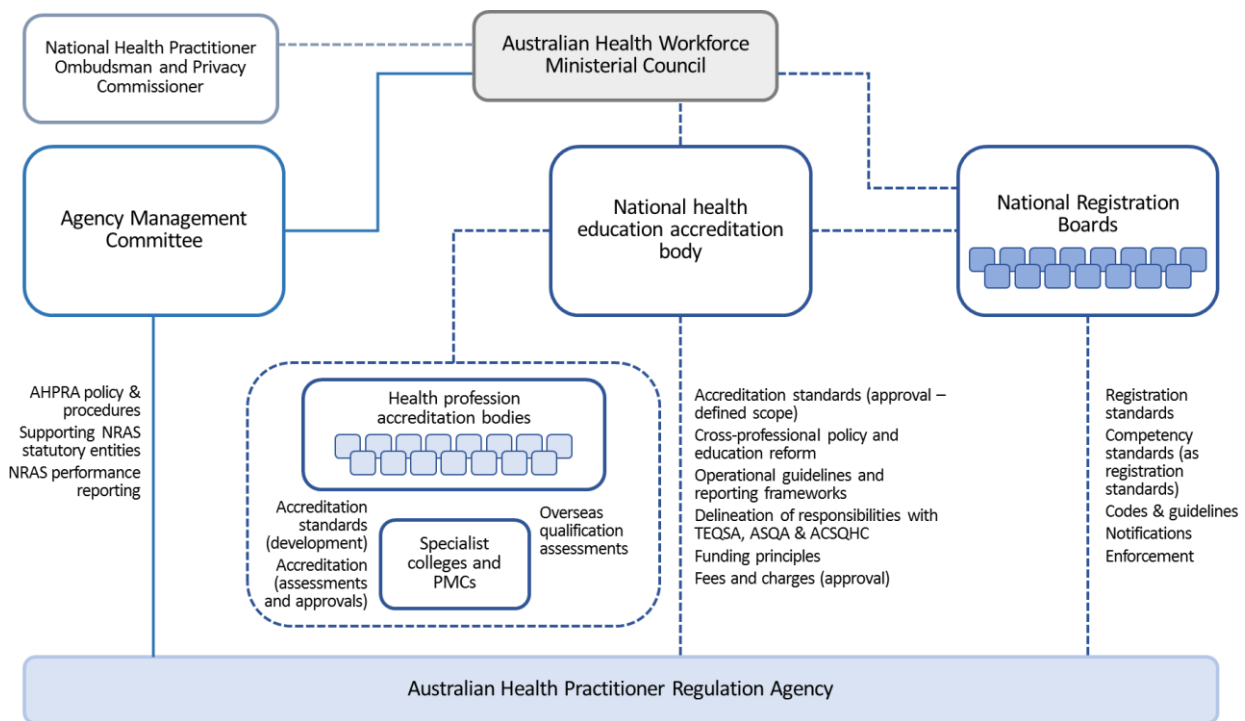


Figure 7.2. Responsibilities and relationships in proposed integrated governance model

This option involves appointing a new body of experts which would be the single point of approval of accreditation standards. It would replace the 14 individual National Board approval arrangements in the current National Scheme. Additionally, the national health education accreditation body would develop common policies and guidelines for education accreditation across the 14 professions, pursue greater interprofessional education, and remove unnecessary overlap with TEQSA and ASQA processes. It would also remove the duplicative decision making by National Registration Boards in the approval of programs of study by vesting that authority solely in the health profession accreditation bodies, provided the programs meet the accreditation standards.

## A national health education accreditation body

A new national health education accreditation body would have the following functions:

- Assignment of profession specific accreditation functions to health profession accreditation bodies (see below).
- Determination of national common cross-profession policies, guidelines and reporting requirements for inclusion in accreditation standards or for recommendation to National Boards for inclusion in professional competency standards. These matters include, for example:
  - The need to ensure teaching approaches reflect methods of contemporary practice, focus on outputs rather than inputs (unless evidence demonstrates otherwise) and respond to national priorities (e.g. adoption of interprofessional education, use of SLEs, clinical education occurring in health settings reflecting contemporary service delivery models).
  - The inclusion of the role of patient centred team based care, cultural safety, national safety and quality standards and areas identified by the Ministerial Council from time to time.
- Development and management of the overall relationships with TEQSA (and the academic boards of self-accrediting higher education institutions), ASQA and ACSQHC, including agreements with those regulators on policies and procedures for the clear delineation of responsibilities between the respective systems and how they interact.
- Approval of accreditation standards developed in accordance with its policies and guidelines. The national health education accreditation body would not have authority over the competency standards (which are an integral part of accreditation) developed by the National Boards.
- Determination of policies and guidelines on the criteria and processes for course accreditation and for assessment of international practitioners, following consultation with stakeholders such as education providers, National Boards, employers, professions, consumers and governments. This would include the development of common standards, fees and charges.
- Determination of what elements of the NSQHS Standards should be incorporated into the accreditation standards and what elements should be recommended to National Boards for inclusion in professional competency standards.

Membership of this body should comprise the expertise necessary to carry out its functions in the public interest. There should be up to 10 members and they should be an appropriate mix of health professional and educational experts, service providers and service users.

## Health profession accreditation bodies

Health profession accreditation bodies (as described in Chapter 6) acting in accordance with the policies and guidelines set by the national health education accreditation body, should have the following functions:

- Developing an accreditation standard for approval.
- Approval of programs of study and education providers for the purposes of registration which meet approved accreditation standards.
- Approval of any action required as identified in the monitoring of programs of study and providers which meet approved accreditation standards.
- Approval of authorities in other countries which conduct examinations for registration in a health profession, or accredit programs of study, and approval of those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia.
- Approval of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession, and advice of the assessment outcome to the relevant National Registration Board.

## National Registration Boards

National Boards would continue to focus on the key elements of the National Scheme covering the regulation of individual practitioners, protecting the public and setting the standards and policies that all registered health practitioners must meet. This would include:

- registration standards and policy
- competency standards
- codes and guidelines
- notifications
- enforcement.

As discussed in Chapter 5, the Review considers the development and approval of competency standards are integral to the National Scheme. It is consistent with the National Registration Boards' focus on individual practitioners that responsibility for these standards rests with them in a more formal manner. National Registration Boards should develop and recommend to the Ministerial Council profession-specific competency standards formally under the National Law in accordance with the legislative provisions established for the development of registration standards.

Whilst the Review considers it unlikely, circumstances could arise where a National Board has concerns about a decision of a health profession accreditation body to accredit a particular program of study. Although the accreditation bodies would be the expert in this area, it would be not unreasonable for the National Law to provide a capacity for National Boards to request further consideration of that decision based on areas of their expertise. Such a provision should operate as follows:

- A National Board may request a review of a decision to accredit a program of study or the provider of that program. That request must be based on the Board's opinion that the program of study would not deliver practitioners with the necessary knowledge, skills and professional attributes in accordance with formally approved profession-specific competency standards. In seeking that review, the National Board must specify the deficiencies in the program of study or performance of the provider.
- A health profession accreditation body must review that program of study against the deficiencies identified by the National Board and either confirm, require changes to the program of study or performance of the provider to rectify any deficiencies or change its decision. The health profession accreditation body must provide a report back to the National Board on its assessment and how any identified deficiencies have been rectified.

The majority of submissions supported a version of this option in the Draft Report (the third option), albeit with some participants outlining caveats. The strongest support came from employers and education provider bodies and those dealing with the accreditation system as whole. Importantly, the views of other regulators and standards organisations were strongly in favour of better defining responsibilities and achieving consistency and integration in the operation of professional accreditation. The key concerns seem to be around the need to ensure profession specific input into accreditation functions and the potential increased bureaucracy and costs. The Review has taken those concerns into account in refining this Final Report Option 2.

### Box 7.3. An integrated accreditation governance body

#### NSW Health

*...the best way of making necessary changes is to remove the accreditation functions from each individual National Board (where they are exercised in silos and duplication occurs) and vest them in another entity under the National Registration and Accreditation Scheme, being a Health Education Accreditation Board. However, whilst the draft report suggests that this would be a "no cost" or "minimal cost" option, due to savings from reduced duplication, NSW Health is concerned about establishment costs and whether these would lead to a significant rise in registration fees. NSW Health would need to be satisfied that this would not occur if Option 3 were implemented. (DR p1)*

#### Hollywood Private Hospital

*By just expanding the existing forums/committees/agencies the delays in the efficiencies and responsiveness will perpetuate. A distinct board with this as its focus seems the logical progression. (DR p6)*

## Box 7.3. An integrated accreditation governance body

**Universities Australia**

*.....a body such as a single Health Education Accreditation Board to which all health professional accreditation committees report will better enable the development of the necessary cross-professional policy and educational reforms. Because of this UA gives in principle support for option 3 in the draft report.... UA broadly supports the uncoupling of educational course accreditation and regulation and registration of individual health practitioners and supports these roles respectively being separately the purview of accreditation committees (educational course accreditation) and national boards (professional registration standards/competencies). UA believes this will significantly reduce variation in accreditation standards and processes..... UA acknowledges the relationship between accreditation of programs of health education/training and development of professional competencies and supports opportunities for these to be contiguous. Again UA sees the recommended governance structure as a useful means to achieve this. however underscores that there should be sufficient flexibility within the proposed reforms for profession-specific input where needed and notes that the draft report has recognised and allowed for this. (DR p8)*

**Australian Council of Deans of Health Sciences**

*ACDHS members note the following principles and would support the option that is best able to provide a governance structure that can deliver on the following*

- *An accreditation system that delivers on all of the objectives set out in the National Law*
- *Coordinated and consistent development of policies, guidelines and reporting requirements, funding principles and fees and charges in order to reduce the financial and administrative costs of accreditation to universities where multiple programs currently require duplication of information.*
- *Agreement on the delineation of responsibilities between the respective accreditation systems (eg TEQSA, ASQA)*
- *Consideration of the possible inclusion of a module within ACSQHC accreditation regimes*
- *Development of an accreditation governance structure that has an appropriate mix of experts in health education, health service provision and health service users, a dedicated secretariat with policy capability, the public interest foremost and provides complete transparency in decision making, professional input to decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders. (DR p12)*

**Edith Cowan University**

*ECU supports the proposed Option 3, outlined in Recommendation 15 in the Draft Report, to establish a Health Education Accreditation Board as the preferred model of governance for the accreditation system. As a fall-back to an Accreditation Board, at least in the short term, ECU suggests that the terms of reference and responsibilities of the Agency Management Committee be extended to include accreditation matters as an interim measure only, until such time as the Accreditation Board can be established through Commonwealth, State and Territory legislatures and commence operations as a fully-functioning independent body with attached secretariat. (DR p7)*

The Higher Education Standards Panel strongly supported the intended outcomes of the Draft Report's third option. As outlined in Chapter 4, the Panel has been asked by the Minister for Education and Training, to advise on the impact of professional accreditation in Australian higher education and opportunities to reduce the regulatory burden on higher education providers and has advised it expects to report by the end of 2017. As part of the Review's consultation process, potential governance arrangements were discussed with the Panel and it has submitted:

*"...the Panel strongly supports the intended outcomes of your "Option 3 — Establish integrated accreditation governance". While the detail of the governance model itself is for the health professions to consider and resolve, this option incorporates significant elements that align closely to the Panel's vision for professional accreditation activity..." (DR p1)*

The national higher education regulator, TEQSA, has similarly indicated its support:

*“TEQSA is supportive of Option 3, establishing an integrated approach to accreditation governance and of the change of the status quo as discussed on page 125, where there is a “Delineation of responsibilities for institutional academic governance and for professional accreditation”. TEQSA believes there is a lot of opportunity for further streamlining in this area and this is where the core of reduced duplication in activity will be achieved.*

*This reduction in duplication should also be reflected in a reduction in cost and compliance burden, particularly if professional bodies adopt risk based approaches to regulation”. (DR p6)*

ASQA, the national VET regulator, whilst not making a submission to the Draft Report, advised the Review that, should the recommended option be accepted, it would be happy to co-operate on implementation.

In relation to the interface with ACSQHC and the importance of the NSQHS Standards in health professional education, ACSQHC submitted:

*“The Australian Commission on Safety and Quality in Health Care (the Commission) strongly supports the direction proposed in the Draft Report of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions.*

*The Review highlights the opportunities to better align the systems for assuring high quality education of health care professionals with the systems for assuring that health services deliver safe, high quality care. The health system is reliant on the skills, knowledge and capabilities of the health workforce to ensure that patients get safe and appropriate care – the accreditation systems for health professional education provide a key opportunity to ensure that there are common understandings across the professions of the actions, processes and systems required to deliver the right care in the right way to the right people.*

*This submission supports the third option for governance reform identified by the Review”. (DR p6-7)*

Support from these national bodies confirms to the Review the potential benefits that could accrue to all parties by providing a more integrated cross-profession approach to accreditation, provided it also has checks and balances that would ensure compliance with profession specific accreditation requirements.

#### *Stage 2 analysis: comparative assessment of an expert Accreditation Committee of the AManC and a separate national health education accreditation body*

As outlined earlier, there are two potential forms of governance for a national body.

- The AManC performing the function, with advice from (or delegation to) an expert Accreditation Committee appointed by the AManC
- A national health education accreditation body which would report to the AHWM Council in the same manner as National Registration Boards and the AManC, and similarly receive directions as appropriate.

An option involving the AManC (the second option) was canvassed in the Draft Report to seek stakeholder views. The AManC’s present role is largely one of managing the functions and polices of AHPRA with its functions defined in s30 of the National Law as follows:

*(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.*

*(2) The affairs of the National Agency are to be controlled by the Agency Management Committee and all acts and things done in the name of, or on behalf of, the National Agency by or with the authority of the Agency Management Committee are taken to have been done by the National Agency.*

The AManC’s current role includes overseeing the development of systems and guidelines for the operation of National Scheme entities and reporting on National Scheme performance. As identified elsewhere in this Report, the Review considers that the current framework of reporting on financial and performance measures in relation to accreditation functions has not been given due attention by the AManC and the Report has recommended improvements in this area.

AHPRA (the National Agency) has its functions primarily defined under s25, with other provisions for specific functions elsewhere in the National Law. In summary its functions are to:

- provide administrative assistance to the National Board
- develop policies and procedures for the operation of the National Boards
- develop procedures for the development of registration standards, codes and guidelines to ensure good regulatory practice
- provide advice and information to the Ministerial Council in relation to the administration of the Scheme.

Importantly, AHPRA gives effect to Board decisions (as National Boards do not have corporate powers). So, for example, agreements with current accreditation authorities are struck with AHPRA. This means that the AHPRA standard agreement has had to be negotiated, firstly with each National Board and then with the respective accreditation council. In addition, profession specific matters are outlined in individual memoranda from each National Board as a schedule to the agreement.

This reflects a complicated governance structure which provides for regulatory decision making by National Boards with corporate actions and overall oversight of performance ultimately accountable to the AManC. The National Law, under s30(1)(c), however, does premise the possibility that AManC could be given distinct and separate functions over and above being the governing body of AHPRA.

Stakeholder views on the AManC taking on responsibility for some of the regulatory functions were mixed:

Box 7.4 An enhanced role for the Agency Management Committee

#### **Medical Deans Australia and New Zealand**

*Expanding the remit of the AHPRA Agency Management Committee may help improve consistency and encourage interprofessional education, particularly if it were able to influence the behaviour of accrediting bodies for the non-registered professions. (DP p8)*

#### **Australian Physiotherapy Association**

*Given the broad responsibilities of the AHPRA Agency Management Committee, membership is unlikely to consist of an adequate skill set for the breadth of health professionals represented by AHPRA. (DP p14)*

#### **Osteopathy Australia**

*Osteopathy Australia had grave concerns with this proposal due to the past and ongoing failures of the AHPRA Agency Management Committee to implement efficiencies and transparencies across the NRAS scheme. Interestingly, despite several NRAS reviews their role at the head of AHPRA or their responsibility to be accountable for the past failures have been completely ignored in favour of blaming National Board or Councils. (DP p5)*

#### **Health Professions Accreditation Collaborative Forum**

*This committee's job is to manage AHPRA, and it has the sorts of business, administrative, legal and health sector skills to perform that role. However, it does not necessarily make sense to ask such a group to take on the additional task of coordinating cross-profession activities in accreditation and ensuring responsiveness to community health needs. (DP p22)*

#### **Department of Health Northern Territory**

*Enhancing the AHPRA Agency Management Committee is not supported. The current focus of the Committee is to manage the business and operational functions of AHPRA under NRAS including support for the functions of National Boards. Apart from the potential conflict of interest if the Committee also had responsibility for accreditation over the boards, the complex nature of the professional and technical skills required would be extensive. (DR p9)*

#### **NSW Health**

*This body is an administrative/governance body and it is inconsistent with the general governance structure of the National Scheme for it to exercise policy functions. Further, NSW Health is not satisfied that this would be a less expensive model. (DR p2)*



## Box 7.4 An enhanced role for the Agency Management Committee

**Pharmacy Board of Australia**

*The current functions of the AManC are clearly set out in Section 30 of the National Law. This articulates that, subject to the directions of the Ministerial Council, the functions of AManC include deciding the operational policies of AHPRA and ensuring that it performs its functions effectively and efficiently. This is consistent with the operational nature of its functions. In other words, AManC has accountability for the operational arm of the National Scheme (which is AHPRA) and not the regulatory policy and decision making functions of the National Scheme (which is a National Board responsibility). (DR p11)*

**Curtin University**

*The report presents three options for reform, all of which have merit. A key issue to address through the reformed structure is to provide an effective mechanism for driving reform and improvement of accreditation across all of the registered health professions in the NRAS. Although the report favours Option 3, it would take several years to action and could become overly bureaucratic and less inclusive of the higher education sector. While Curtin sees potential merit in a single health education accreditation board or committee, this function could be better addressed by enhancing the Agency Management Committee. (DR p5)*

**Commonwealth Department of Health**

*The Department's initial submission supported a broadening of the role of the Agency Management Committee (AManC) to provide formal oversight of accreditation to support the councils in discharging their responsibilities for accreditation. The AManC working within AHPRA structures and accreditation councils would be well placed to implement recommendations to increase efficiency, consistency and transparency across the different professions, while maintaining professional integrity. (DR p7)*

**Council of Ambulance Authorities**

*...the Committee was set up for another purpose and does not within its current membership contain specialist advisors on accreditation processes. To achieve accreditation reform the AManC would need to be massively expanded and deal with issues which are not its core function, and could result in a loss of focus for the committee. Because the AManC is closely aligned with AHPRA and the National Boards, it may not attract the acceptance by the educational sector. The current NRAS Governance Review is also considering the role of the AManC and its final recommendations may not align with those of this review. (DR p6)*

As noted in this Review's scope, it is possible that the NRAS Governance Review may be considering proposals for other governance changes that impact of the role of the AManC. It is understood that this includes consideration of the allocation of various functions in the context of the current statutory roles and observations made in the 2014 [NRAS Review](#) that:

*"...there is neither obligation nor accountability for the performance of the National Scheme as a whole in terms of meeting its objectives. This was particularly evident in relation to the objectives regarding workforce reform that require collaboration between groups within the National Scheme, as well as stakeholders more broadly". (p15)*

With the aim of limiting the complexity of National Scheme governance, the Review is not averse to expanding the role of the AManC to take on functions as outlined under this Option. However, such a decision should not be made in isolation of other broader governance options that may be considered in the current NRAS Governance Review. The configuration and skill mix of the AManC would also need to be reviewed to reflect the enhanced role. If the AManC formally delegated the education accreditation function to a standing committee:

- the process for selecting members of the standing committee should be transparent
- the standing committee must place the public interest and National Scheme objectives foremost and undertake decision making based on expertise of individuals and provide complete transparency
- the standing committee must exercise its functions independently of the interests of particular stakeholders.
- Its decisions should be transparent and subject to regulatory scrutiny.

Under either the AManC or separate national health education accreditation body form of governance under Option 2, there needs to be clarity in the roles assigned to all National Scheme entities. Enhanced and comprehensive reporting systems and measures need to be put in place to provide a transparent platform for performance monitoring and continuous improvement.

In considering whether to support either the AManC or a separate national health education accreditation body as the responsible entity, the Review has noted the relatively common viewpoint in those submissions which argued against providing such responsibilities to the AManC. This view was that such a change would represent a fundamental shift in the National Law where AManC has specific accountability for the operational arm of the National Scheme and not the regulatory policy and decision-making functions.

There has been associated concern that giving this function to the AManC effectively increases the reach of involvement, if not actual control, of AHPRA over the functions of the National Scheme. A counter to this, to some extent, is the current lack of an entity within the National Scheme which can be held accountable for the overall performance of the Scheme.

The Review considers, on balance that there is greater merit in establishing a separate statutory national health education accreditation body with responsibility for overseeing the accreditation function and the operation of the health profession accreditation bodies. The benefits include:

- a dedicated and expert cross profession approach to accreditation whilst preserving the best features of current arrangements
- improved reporting on performance, enabling a more direct focus on accreditation system efficiency and effectiveness
- a locus of accountability for continuous improvement
- clarity in function that avoids risks of being complicated and delayed by broader considerations of overall National Scheme governance.

### *Impact assessment of Option 2*

#### Benefits

The assessed reform benefits of Option 2, irrespective of whether the form of governance body should be the AManC or a separate national health education accreditation body, would include:

- Enabling entities within the National Scheme to better understand the proportionate and transparent balancing of all National Law objectives and guiding principles.
- Improving the National Scheme's governance capacity by allocating functions to entities with the most relevant expertise. A more robust and clear system will provide governments, stakeholders and the community with confidence that the arrangements can deliver continuous improvement of the standards, assessment processes and overall performance of the accreditation scheme. It will also ensure that regulatory administration remains relevant and effective over time.
- Ensuring that, where there are more competent regulatory authorities (both within and external to the National Scheme), they are utilised. There would be more efficient and effective integration with the accreditation systems for higher and vocational education programs (TEQSA and ASQA) and with the accreditation of safety and quality in the delivery of health services (ACSQHC) across professions.
- Creating a principles-based regulatory framework that can minimise compliance costs and is efficient, effective and transparent. This would include delivering on the best practice principles of separating the standard setting function from the function of assessing compliance against those standards.
- Progressing accreditation reforms in a manner that promotes cross-profession policies and guidelines, while ensuring the input of profession-specific expertise where necessary.
- Recognising that, as private companies, accreditation councils can have other commercial arrangements provided their contracted accreditation functions are managed independently and transparently. Application of such requirements would only be to those functions specified under the National Law. This would provide the most effective means to ensure complete transparency in decision making and that those functions are subject to the same requirements as all other decisions made by entities specified under the Health Practitioner Regulation National Law Regulation 2010. These requirements include privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.

- Removing duplicative approaches across government agencies to the assessment of qualifications and skills of international practitioners seeking to work in Australia.
- Enabling National Boards to formalise practitioner competency requirements and their embedding in accreditation standards and curriculum design.
- More effectively apportioning responsibilities in a manner that enables AHPRA and the National Boards to continue to focus on the specific practitioner regulation work they have prioritised in the Annual Reports and their published strategic plans.

## Risks

The Review has identified two key risks in this reform option:

- profession-specific knowledge and input could be reduced
- the entities within the National Scheme do not approach their respective regulatory responsibilities cooperatively and the National Law objectives are not appropriately balanced.

To ensure that profession-based input is not only preserved but enhanced, the Review has proposed that the existing profession-based accreditation authorities should be able to operate their accreditation function in a more independent manner, but with clear public accountability requirements established for their accreditation responsibilities under the National Scheme.

Such a model should ensure that expertise in profession-specific accreditation is accessed and applied within an overarching framework of transparency and review, and within a policy framework that is designed to develop a workforce that can support evolving health care delivery approaches.

In relation to the appropriate exercising and balancing of functions within the National Scheme, as outlined earlier, a major consideration of the Review is to ensure that in this model the National Registration Boards, and the system as a whole, continue to have trust in the integrity of the accreditation institutions and processes.

Formalising competency standards as a function of National Boards and assigning expert bodies to accredit programs against accreditation standards that include those competency standards provides a sound platform for retaining that trust. The additional proposed capacity for National Boards to request further consideration of an accreditation decision based their view that competency standards are not being met should further build on that trust.

While it would be expected that regulatory cooperation would be a bottom line requirement, it would be enhanced through the proposed Statement of Expectations approach outlined in Chapter 8. This could include expectations around regulatory cooperation and the operation of working partnerships with other entities within and external to the National Scheme. This could be enhanced by relevant National Scheme entities producing Statements of Intent in response that outline how the expectations would be met.

### *Stage 3 analysis: assessing the financial benefits and costs of change*

## Benefits

Overall, the Review considers that the governance reforms proposed in Option 2 above, together with the more timely and fulsome implementation of reforms proposed elsewhere in this Report, will result in reductions in costs and burdens. These reductions could then be reflected in reduced fees charged to education providers and in the components of registrant fees supporting accreditation functions. Quantification of this, however, can only occur as the precise elements of the new accreditation model are developed. As outlined in Chapter 3:

- Each accreditation authority currently has a different charging regime and charges different fees for accreditation functions and for the assessment of overseas trained health practitioners. Once the delineation of accreditation requirements with TEQSA and ASQA is established, reductions in fees can be identified commensurate with the reduced assessment workload in accreditation authorities.
- Costs and burdens incurred by education providers would be reduced commensurate with decreases in their accreditation preparatory and compliance work. Education providers also incur accreditation costs through TEQSA and ASQA processes and the proposed model would result in this work only being required once for a number of common accreditation elements across all regimes.
- The adoption of transparent cost recovery models for functions where accreditation authorities are currently generating surpluses would lead to a more efficient charging regime.

The funding framework and cost recovery model will need to factor in the establishment of a consolidated funding stream that can support the development of common accreditation standards, joint projects, and other cross-profession and oversight functions. It is expected, however, most of those costs can be funded through the transfer of current 'indirect expenses' allocated to AHPRA within HPAs for the administration of accreditation activities.

These indirect expenses budgets are agreed with each National Registration Board. Even though AHPRA is unable to quantify the amounts, it has advised the Review that:

*"The explanation of indirect expenditure in the HPA states: 'AHPRA supports the work of the National Boards and committees by employing all staff and providing systems and infrastructure to manage core regulatory (registration, notifications, compliance, accreditation and professional standards) and support services in eight state and territory offices.*

*AHPRA supports all National Boards (those that have assigned accreditation functions to an external entity and those that have established Committees) by employing all staff and providing systems and infrastructure to manage the aspects of Part 6, Division 3 Accreditation Functions that apply to National Boards/AHPRA such as:*

- *Decision on accreditation entity (section 43)*
- *Management of contracts with accreditation entities including the Agreement for the Accreditation Functions and the annual funding and revised schedules to that agreement and reports against the Quality framework under that Agreement (section 44)*
- *Approval and publication of accreditation standards and relevant written notices (section 47)*
- *Approval of accredited programs and relevant written notices*
- *Changes to approval of programs and relevant written notices*
- *Maintaining the published list of approved programs*

*AHPRA also engages in a range of other activities such as support for the Accreditation Liaison Group".*

With the transfer of these functions the accompanying resources could be transferred to support the new arrangements without additional costs. Indeed, there would be further savings from this reform as National Boards (and AHPRA staff) will no longer review and evaluate recommendations from health profession accreditation bodies on programs of study. These savings could be deployed to further enhance policy capability to support the national health education accreditation body.

The Review sought more detail from AHPRA on whether it could quantify AHPRA resources supporting National Boards in relation to accreditation matters. AHPRA advised:

*"AHPRA staff provide their usual advice, guidance and support in preparation of the Board papers on issues that may require decisions. This would generally include analysis of any reports on accreditation decisions or monitoring, half yearly and annual reports against the quality framework and any new or revised accreditation standards. The level of analysis and amount of work done by AHPRA staff varies depending on the type of report or complexity of the issue. The work is generally performed by the Executive Officer with input, as required, from Policy Officers and the Specialist Accreditation Advisor".*

The Review accepts that the AHPRA consolidated budget and staffing model makes it difficult to match individual savings to the transfer of certain functions. Conversely, the Review considers that the AHPRA model thus makes it relatively easy to identify global net savings across the consolidated AHPRA support resources that could be redeployed.

As a further benefit, a drive for efficiency and cost savings may lead to some authorities to explore functional mergers, as is currently the case for some accreditation councils.

## Costs

Two categories of costs that need to be assessed in considering the Options:

1. **Policy and program resources to progress the necessary reforms.** There is almost universal acceptance of the Review's proposals to develop common and cross professional policies and guidelines, establish appropriate links with other systems and improve the efficiency and effectiveness of the system overall. Equally, the lack of resources in this area has been identified by many parties. The Review considers an estimate of the necessary resource requirements would be identical across both Options 1 and 2.

The Review considers an initial allocation of 4 FTE would be required to support progressing the reforms for the first 12 months and this should reduce to 3 FTE on an ongoing basis. AHPRA, however, has advised there is an existing FTE allocated to undertake policy work for the ALG and recently further advised that it has allocated an additional FTE to the creation of a Specialist Accreditation Advisor position. Given the existing 2 FTE, the net 2 FTE increase would be at a cost of \$266,000 per annum, based on AHPRA staff cost model. The Review is confident that, with the workload reductions identified above, and an overall AHPRA FTE of 870 (87 of those are classified as working in policy and strategy), these resources can be provided at no or minimal extra cost.

2. **Funding to support revised governance arrangements.** All options also recognise the need for a more integrated approach to accreditation governance, be it by either advisory committee or determinative body. Unfortunately, however, in the different committee options put forward in the HPACF or in the joint AHPRA/National Boards submissions, whilst they argued against the cost of the preferred option presented in the Draft Report, neither sought to quantify their costs.

The Review's best estimate of these costs includes the following assumptions:

- AHPRA policy provides that sitting fees for National Boards and all official committees are identical so the Review has assumed identical costs whether it be either a committee as proposed in Option 1 or either a national health education accreditation body or a committee of AManC in Option 2.
- The HPACF and ALG would continue in largely their current forms, acting as advisory groups or to oversight specific work requested by the governance bodies in both Options 1 and 2.
  - AHPRA already provides administrative support for the ALG and funds any committee sitting fees of National Board representatives or nominees.
  - HPACF members already fund administrative support for Forum meetings and operations and it is thus assumed this is accounted for in members' budgets. It is understood members attend as part of normal work, so their expenses are already funded by the member organisations.
- Greater use would be made of the AHPRA Community Reference Group to enhance consumer input.

Operational cost estimates for the governance bodies have been based on the template for the creation of the new Paramedicine Board of Australia. This was developed by AHPRA in 2016 and has been updated by the Review to reflect 2017 AHPRA rates. These costs include sitting fees, on costs and board/committee member expenses. Based on an expected 12 meetings per year for the governance bodies an estimate of 0.4FTE has been made for administrative and clerical support.

For **Option 1**, as outlined earlier in this chapter, the HPACF proposed *"a committee to oversight interprofessional issues with representation from national boards, accreditation authorities, and AHPRA, as well as consumer representatives and education providers,"* however, numbers were not provided. The Review has assumed this would not be all National Boards and accreditation authorities and thus estimated National Board members (5), accreditation authority representatives (5) consumer representatives (2) and education providers (6). Sitting fees and expenses would be payable to up to thirteen people, excluding nominees of accreditation authorities. Based on an expected 12 meetings per annum the Review estimates the annual cost of operating this committee would be approximately \$418,000 per annum.

For **Option 2** the Review's cost assessment includes the general assumptions listed above. The Review has proposed for the national health education accreditation body there should be up to 10 members and an appropriate mix of educational and health professional experts, service providers and service users. In this circumstance, 9 members are estimated, with sitting fees and expenses paid to all sitting members. Based on an expected 12 meetings per annum the Review estimates the annual cost of operating this Board would be approximately \$301,000 per annum.

The expert committee of the AManC model proposed in the joint submission by AHPRA and the National Boards to the Draft Report also did not specify the size or makeup of that committee. For the sake of comparison, therefore, the Review has assumed an identical size and thus cost (\$301,000), noting its costs could be greater or lesser depending on the number of members.

Overall it is apparent that the only cost variation between any of the options would result from the number of appointed members and should thus not be the determinant factor in choosing an option. Further, in all options the Review is confident that accrued savings achieved through the range of recommendations provided in this Report could be, firstly, applied to meet these costs and then, secondly, reflected in reduced fees charged to education providers and in the components of registrant fees supporting accreditation functions.

## Preferred governance model

In summary, the Review concludes that Option 2 should be implemented, irrespective of whether the form of governance body should be the AManC or a separate national health education accreditation body. It is designed to reduce regulatory burdens, allocate functions efficiently and effectively and minimise compliance costs, provide stability, and operate transparently. It takes up the opportunities offered through recent reforms in education and health, ensuring that, where there are more competent regulatory authorities they are utilised or able to better interface with the National scheme as a whole.

Critically, the Review is conscious of the need to provide a system that can respond to current issues and those arising into the future and ensure that regulatory administration remains relevant and effective over time. A more robust and clear system will provide governments, stakeholders and the community with confidence that the arrangements can deliver continuous improvement in the performance of the accreditation scheme.

The Review prefers the establishment of a separate national health education accreditation body as the preferred mechanism for advancing Option 2, providing a dedicated and expert cross profession approach to accreditation whilst preserving the best features of current arrangements. However, in the context of governance simplicity and alignment with any broader National Scheme governance reform, the Review is not averse to expanding the role of the AManC to take on these functions.

### Recommendations

19. Governments should establish in the National Law a national health education accreditation body with the following responsibilities:
  - a. Assignment of accreditation functions to health profession accreditation bodies either individually or, where agreed, to amalgamated bodies, in accordance with Recommendations 16,17 & 18
  - b. Collaboration with other National Scheme entities to design and implement the operational interface between accreditation and registration
  - c. Determination of policies, principles, guidelines and reporting requirements, as appropriate, in relation to Recommendations 1, 3, 4, 5, 6 & 7
  - d. Approval of fees and charges proposed by health profession accreditation bodies in accordance with Recommendation 1
  - e. Development and management of the overall relationships with TEQSA (and the academic boards of self-accrediting higher education institutions) and ASQA, in accordance with Recommendation 5, including agreements with those regulators that encompass the following parameters:
    - i. Institutional academic accreditation to be undertaken by TEQSA-approved structures for higher education providers or ASQA-approved structures for Registered Training Organisations.
    - ii. Professional accreditation to be undertaken by accreditation authorities
  - f. Approval of accreditation standards developed in accordance with its policies and guidelines.
  - g. In partnership with the ACSQHC, determination of the elements of the NSQHS Standards that should be incorporated into the accreditation standards and the elements that should be recommended to National Boards for inclusion in professional competency standards
  - h. In partnership with ACSQHC, exploration of the potential to include a module within ACSQHC accreditation regimes that encompasses the health service elements of the clinical education/experience domain in professional accreditation.



## Recommendations

20. If Governments determine that the functions of the national health education accreditation body should be conducted by the Agency Management Committee, they should ensure that:
  - a. Any decision should not be made in isolation of consideration of other broader governance matters and should ensure there is clarity in roles assigned across all National Scheme entities.
  - b. Enhanced and comprehensive reporting systems and measures are put in place to provide a transparent platform for performance monitoring and continuous improvement.
  - c. The configuration and skill mix of the Agency Management Committee is reviewed to reflect the enhanced role and, if the model to be adopted is one where the Agency Management Committee delegates this role to a standing committee:
    - i. the process for selecting members for that committee should be transparent and the committee must provide decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders
    - ii. the committee must place the public interest foremost and provide complete transparency in decision making.
21. A National Board may request a health profession accreditation body to review a decision to accredit a program of study as follows:
  - a. The request for review must be based on the National Board's opinion that the program of study would not deliver practitioners with the necessary knowledge, skills and professional attributes in accordance with formally approved profession-specific competency standards. In seeking that review, the National Board must specify where in the program of study it considers there are deficiencies.
  - b. The health profession accreditation body must review that program of study against the deficiencies identified by the National Board and either confirm, change its decision or require changes to the program of study to rectify any deficiencies. The health profession accreditation body must provide a report back to the National Board on its assessment and how any deficiencies identified by the National Board have been dealt with.
22. The national health education accreditation body should invite current accreditation authorities to establish health profession accreditation bodies for the initial five-year period.
23. Following the initial five-year period, the national health education accreditation body should seek expressions of interest and assign profession specific accreditation functions for periods of five years.

## Consideration of the unregistered professions

The opportunity to consider the accreditation of unregistered professions in the overall reform of accreditation of health education under the National Scheme was raised in a number of submissions. Unregistered professions operate outside of the National Scheme's regulatory regime, though the Review acknowledges that many have some form of self-regulatory governance structures.

In particular, this issue was a major theme in the submission from the Australian Council of Deans of Health Sciences (ACDHS).

*"There would be advantage in broadening the scope of the accreditation structure and processes within NRAS to include the self-regulating professions rather than having a parallel structure with potentially differing requirements. This suggestion is not to presuppose that these professions would require registration, but rather the inclusion of the self-regulating professions could reduce the variability in accreditation requirements across all health professions". (DP p4)*

*"Whilst establishing a single accreditation standard may be the ideal; unless all of the professions currently within NRAS (and ideally the self-regulating professions) are included, the progression of cross profession development, education and accreditation consistency and efficiency will be sub optimal ... the scope should include all of the regulated professions covered by NRAS and ideally consider including self-regulating health professions under a broader accreditation function". (DP p24)*

The Review considers that the ACDHS makes a compelling point, and many submissions supported the proposal. At the same time, the concerns expressed by some parties. Is understandable. How such an approach could be implemented would need to be carefully considered to ensure there are no unintended consequences and it is acknowledged that further consultation and investigation would be desirable.

Understanding that this is an accreditation as well as a registration scheme, a major theme of the Review, however, has been to propose new governance arrangements that are forward looking and cognizant of the broader context that takes account of interactions of all health care with social and other services in responding to community needs. Providing capacity to support the accreditation of the education of relevant unregistered professions is consistent with this view. Introducing this flexibility into the National Scheme could:

- provide a foundation for further consistency across a range of health and social care professions
- enable cooperative participation in the inclusion of common competencies
- support the development of education models that facilitate integrated service responses with a greater client focus, tackling issues associated with as social disadvantage, mental health, insecure housing, family violence, drugs and alcohol, chronic health conditions, disability, frailty and access to services
- provide capability to support requests from ASQA when it is asked to consider the accreditation of VET courses and it requires expert advice on the safety and technical practice elements of competencies being taught.

The Review is thus proposing that the legislative arrangements be designed **so as not to prohibit** the future limited participation of other unregistered health and social care professions in certain matters. This would enable further exploration and consultation by jurisdictions and other interested parties as the accreditation system matures. Any final decision would thus not require further legislative amendment, which, given the design of the National Law arrangements across Australia, has been identified in a number of submissions as cumbersome and protracted. A more viable option could be approval by the Ministerial Council.

As outlined in the Draft Report, the Review considers there are threshold conditions that would need to be met in any decision that permitted unregistered health and social care professions to apply to access the skills and expertise available by, and operate their accreditation activities with the support of, the accreditation regime:

- Unregistered professions participating in the accreditation model would be identified as being in a separate category to National Scheme registered professions.
- Accreditation activities undertaken by unregistered professions within this framework would have no implications for the registration of that profession. All applications for registration would continue to be dealt with through established Ministerial Council processes and in accordance with the COAG agreed criteria.

## Recommendation

24. Governments should ensure the National Law does not prohibit the future limited participation of unregistered health and social care professions through access to the skills and expertise of the accreditation regime and operation of their accreditation activities with its support, subject to the following conditions:
- a. Participation should be subject to COAG Health Council approval and consultation with stakeholders
  - b. Unregistered professions participating in the accreditation provisions of the National Law would be identified as being in a separate category to the registered professions.
  - c. Accreditation activities undertaken by unregistered professions would have no implications for the registration of that profession. All applications for registration would continue to be dealt with through established COAG Health Council processes and in accordance with the COAG agreed criteria.

## 8 Other governance matters



In the course of the Review, several matters were identified that reflected the bespoke nature of the final configuration of the National Scheme. This was a consequence of moving from individual arrangements in eight jurisdictions for 14 different professions, supported in different ways by a wide range of entities. The matters raised were the assessment of overseas trained practitioners, the functions of specialist colleges and postgraduate medical councils, and grievance and appeals processes.

In each instance, the Review assessed whether the matters were in scope, whether they needed separate and detailed consideration and how they fitted into this Review's examination of accreditation functions and the broader governance changes under consideration.

### Key messages

The purpose of a skilled migration assessment is to test whether the applicant can work in that profession in Australia. In the case of registered health professions, this requirement is, in the first instance, registration under the National Scheme. Current processes for skilled migration and registration, however, are separate and success in one does not guarantee success in other.

A one step approach to assessing overseas trained practitioners for skilled migration and registration undertaken by the accreditation authority is achievable and is in place for medicine and physiotherapy.

Accreditation and assessment activities undertaken by specialist colleges within the National Scheme are similar to those being undertaken by the 14 accreditation authorities and all recommendations relating to efficiency, transparency and governance applying to accreditation authorities should also apply to specialist medical, dental and podiatry colleges.

Accreditation decisions made under National Law should be subject to the same privacy, FOI and oversight by the National Health Practitioner Ombudsman and Privacy Commissioner as decisions made by other entities within the National Scheme.

Planning for the future workforce must be embedded within national health system reform priorities. The Australian Health Workforce Ministerial Council should define these priorities and formalise its expectations from the National Scheme.

### Assessment of overseas trained health practitioners

Overseas trained health practitioners who are seeking to practise in Australia must engage with numerous organisations (immigration, state and territory governments, recruitment agencies, National Boards, AHPRA and employers) as part of the process for accreditation, registration and skills assessment.

The National Law (s42) defines qualifications assessment for registration of overseas practitioners as accreditation functions, as follows:

- a) *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.*
- b) *Overseeing 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.*

As noted in Chapter 6, the classification of the assessment of overseas trained practitioners as both a registration and accreditation function reflects legacy arrangements from previous state and territory schemes. The National Law enables National Boards under s35(e) to assess overseas trained practitioners.

Section 53 of the National Law states that an individual is deemed to be qualified for general registration if that individual either holds:

- an approved qualification
- a qualification that is considered substantially comparable or based on similar competencies to an approved qualification
- has successfully completed and an examination or other assessment required by the National Board.

## Overseas qualification assessment approaches across professions

The Review has sought to map the assessment processes across the 14 professions and additional specialties within those professions. It is a diverse and often complex landscape:

- Pathways and assessment techniques vary considerably across professions.
- The chiropractic, dental, medical, nursing and midwifery, osteopathy, pharmacy, physiotherapy and podiatry professions undertake assessments of overseas authorities as well as assessment of overseas trained practitioners. The professions have differing approaches to progressing and applying overseas competent authority pathways.
- The Nursing and Midwifery and the Psychology accreditation councils and the three accreditation committees do not have a role in assessing overseas trained practitioners or assessing authorities in other countries that conduct examinations for registration in a health profession or accredit programs of study relevant to registration in a health profession ('overseas authorities'). For these professions, the National Board undertakes this role.
- Where assessment decisions impose additional requirements (such as supervised practice or examinations), the reasons for these decisions are not made clear.
- Appeals processes are clear in some circumstances and not in others.

The Review sought views from stakeholders on whether there should be consistency across the professions in assessment pathways, approaches and granting of registration status for overseas trained practitioners. The National Boards/AHPRA joint response to the Discussion Paper indicated a willingness to develop common protocols:

*"The National Law provides multiple pathways to assess overseas qualified practitioners, which provides regulatory flexibility to respond to the risk profile of the profession, volume of overseas qualified applicants seeking registration and other considerations including workforce needs. There are options both in terms of the pathways to qualify for registration and in terms of the types of registration ... If more consistent approaches are desirable, there is scope to develop common protocols about assessment across all bodies undertaking this function". (DP p15)*

The Health Professions Accreditation Collaborative Forum (HPACF) was less receptive to a more consistent approach. In its submission to the Discussion Paper it highlighted:

*"Given the wide diversity of settings, treatment modalities, specific skills and levels of risk reflected in the groupings of health professions captured by the NRAS scheme, consistency of assessment process is unlikely to be achievable let alone desirable ... More important than consistency across all professions is that processes adopted for assessment by individual professions are relevant to the needs of that profession and delivered in a fair and transparent manner. This does not require all assessment processes to adopt the same format". (DP p26)*

The Royal Australasian College of Surgeons (RACS) in its submission to the Draft Report noted:

*"Consistent approaches across the National Boards are to be encouraged where they are relevant and workable, however there are differences in the way that the specialties are practiced, and consequently there are valid differences in processes for assessment. Processes should be designed to ensure that the best assessment outcome is achieved for the clinician and the patient, even if that means there are differences between National Boards". (DR p1)*

The Australian and New Zealand College of Anaesthetists (ANZCA) in its response to the Draft Report supported the concept of consistency, but also drew attention to the professional uniqueness of assessing clinical competencies:

*“ANZCA supports the concept of consistency in the major steps of the process of assessing overseas trained practitioners for the purposes of skilled migration and registration, however the assessment of clinical competencies will always need to be appropriately tailored to specific profession groups”. (DR p11)*

The New Zealand Dental Council in its response to the Discussion Paper also highlighted areas where a consistent approach would be desirable.

*“Our experience in New Zealand has been that there is significant overlap on a registration policy level on entry level standards, which allows for potential streamlining of registration processes. This could be more easily achieved within the context of a central regulatory authority ... On a principle level, the Council believes that once threshold entry standards have been met, registrants should be able to practise independently; as they have been considered competent to practise within their specific area of practice. Particularly registrants from competent authority jurisdictions where the entry level standards have been considered in detail, and determined to be equivalent to Australia. Similarly, a candidate that has passed a registration examination should be able to practise independently. Robust examinations should provide the necessary assurance that an applicant that has passed is competent and safe to practice”. (DP p10)*

There are several benefits in providing greater consistency in both application and assessment steps across professions. These include consistency in provision of information to the applicant as well as a reduction in costs through pooling of infrastructure (for example, use of a single application and assessment portal, and international examination sites). Benefits could also accrue for the administration of those processes, including primary source verification of overseas education qualifications and organisation of interviews and clinical assessments.

The National Boards/AHPRA joint submissions to the Discussion Paper and the Draft Report have expressed a willingness to review current processes and explore opportunities for consistency, transparency and reduced duplication. The Review notes that elements of the registration process have been centralised (such as checking English language requirements and criminal history) and there is scope to expand this to include an integrated assessment process for overseas trained practitioners for skilled migration and registration.

## Skilled migration visas versus registration

To work as a registered health practitioner in Australia, it is necessary to gain registration through the relevant National Board. Overseas trained practitioners may also need to apply for a qualifications assessment for a skilled migration visa issued by the Australian Department of Immigration and Border Protection.

### *Skills assessment bodies*

Approval of bodies to perform the skills assessment function for migration purposes for the relevant occupations is through gazettal by the Minister for Immigration, under s22.6B of the [Migration Regulations 1994](#). The Regulations require the Minister for Immigration to seek approval when selecting an assessment authority to undertake the skills assessment function. In the case of registered health practitioners under the National Scheme, the Commonwealth Minister for Education and Training provides this approval.

This Review has consulted the Commonwealth Department of Education and Training (DET) regarding the criteria used by the Minister when approving skilled migration assessing authorities. The DET *Guidelines for skilled migration assessing authorities* ('the Guidelines') specify five criteria, which form the basis for assigning skilled migration assessment functions:

**Criterion 1:** *The body is financially viable and has administrative structures, policies and processes to operate effectively as an assessing authority;*

**Criterion 2:** *The body represents the nominated occupation nationally and has written support from relevant organisations to operate as the assessing authority for the nominated occupation;*

**Criterion 3:** *The body has assessment standards that are consistent with standards needed for employment in the nominated occupation in Australia and has appropriate processes for assessing applicants against these standards;*

**Criterion 4:** *The body will clearly inform prospective migrants about skills assessments; and*

**Criterion 5:** *The body has an appropriate review and/or appeal process for its skills assessments.*



While all criteria apply equally, Criterion 3 is the most relevant to this Review as it requires assessment standards used by assessing authorities (for skilled migration) to be consistent with standards for employment in Australia. The Guidelines detail the required evidence. In the case of registered professions, given that registration is required for employment, eligibility for registration would be the expected standard.

In 2012, the responsible Minister under the Migration Regulations, [gazetted](#) a range of Assessing Authorities for General Skilled Migration Visas including the Australian Nursing and Midwifery Accreditation Council (ANMAC), Council on Chiropractic Education Australasia, Australasian Osteopathic Accreditation Council, Australian Dental Council (ADC), Australian Physiotherapy Council (APhysioC), Australian Pharmacy Council, Australian and New Zealand Podiatry Accreditation Council, Occupational Therapy Council (Australia and New Zealand) and the Optometry Council of Australia and New Zealand.

In certain cases, assessment is undertaken by peak bodies or other designated entities; such as the Vocational Education and Training Assessment Services who assesses dental hygienists, dental therapists, ambulance officers, intensive care paramedics and Aboriginal and Torres Strait Islander health workers.

As outlined in Chapter 6, the Chinese Medicine Board of Australia is the assessing authority for acupuncturists and traditional Chinese medicine. The Medical Board of Australia is the assessing authority for medical practitioners. Importantly, registration (instead of education and training) has been set as the appropriate benchmark for general or specialist recognition in medicine for skilled migration. As noted by the Australian Medical Council (AMC) in its submission to the Discussion Paper:

*“... evidence of full medical registration is a suitable skills assessment for Points Tested Skilled Migration, so alignment of migration and registration requirements exists in the case of medicine. Prior to registration applicants must undergo assessment conducted by the AMC”. (DP p29)*

The majority of National Boards make it clear that the application processes for skilled migration and registration are separate, and success in one does not guarantee success in the other. For medicine, however, registration is considered suitable for Points Tested Skilled Migration. Physiotherapy and Dentistry (for dentists only) have also aligned the qualification assessment requirements and processes for both registration and skilled migration. APhysioC in its submission to the Discussion Paper advised:

*“The Council is delegated the authority to assess the qualifications of overseas qualified physiotherapists for the purpose of general registration with the Physiotherapy Board of Australia... As the Department of Immigration and Border Protection gazetted ‘skills assessing authority’, the Council also assesses the relevant skilled employment experience of skilled migrants under the General Skilled Migration framework”. (DP p10)*

#### *Aligning migration skills assessment and registration*

The skilled migration Guidelines require the assessment to be:

- able to be met through skills, qualifications and/or experience relevant to the occupation
- not less or more than those an Australian would need to meet for employment in the occupation
- based on the standards for licensing or registration and/or the Australian Qualifications Framework
- flexible enough to allow an applicant to meet the standards through a variety of pathways
- the minimum required to assess the applicant against the standards
- in the case of exams, be available at appropriate intervals throughout the year and in a range of locations, taking into account costs, feasibility, number of assessments and visa issues.

DET also advised that:

*“Skilled migration assessments must be appropriate and not pose unreasonable barriers to migration. In practice this means that skilled migration assessments must be accessible to applicants who are not residing in Australia. Registration under NRAS does not have this remit and subsequently can include requirements such as periods of supervised practice, which require residency in Australia”.*

Clearly this needs to be further explored, as requirements for supervised practice in Australia do not constrain alignment between registration and skilled migration. This has been demonstrated by the Medical Board of Australia, (which does place conditions of supervised practice for general registration), and the AMC, which has aligned its processes to enable a one-step approach.

### Exploring a one-step approach

Officials from DET advised the Review of their willingness to work with National Boards and accreditation bodies to develop a one-step approach to assessment for the purposes of both skilled migration and registration. National Boards and AHPRA, in their joint submission to the Discussion Paper, acknowledged this opportunity:

*“We recognise the scope to reduce duplication in this area and support proposals to align the assessment of qualifications for individuals seeking both skilled migration visas and registration in Australia. This alignment can occur in two ways – recognising the individual’s registration status for visa purposes as currently occurs for the medical and Chinese medicine professions or the same body being responsible for both assessments and the outcome being used for both purposes (such as the Australian Dental Council assessment for overseas qualified dentists)”. (DP p15)*

In its submission to the Draft Report, AHPRA and National Boards further noted that the current separate approach to skilled migration and registration was also impacting on international students:

*“... international students who complete accredited domestic programs must apply to accreditation councils for a skills assessment even when they hold general registration. This can lead to delays in employment because they need to wait for the skills assessment to get a suitable visa. For some professions with high numbers of international students, this can be a significant proportion of applicants for assessment for skilled migration purposes”. (DR p14)*

A number of stakeholders expressed a preference for a one-step approach.

#### Box 8.1. Views on a one-step qualification assessment process

##### Commonwealth Department of Health

*The Commonwealth Department of Health supports a one step process for assessing overseas health practitioners for permanent skill visa requirements and for registration. This process could be facilitated either through the accreditation council or the national boards ... The assessment of overseas trained health practitioners must include a skills based assessment process and not be reliant on a minimum level of qualification that is assessed equivalent to the Australian qualification framework level. (DP p3)*

##### Australian Pharmacy Council

*... there is duplication in the existing arrangement between assessment for skilled migration and assessment for registration functions. We cannot see why these are not aligned for all professions, as there is considerable overlap for some of the requirements. Alignment for all professions to the accreditation authority could reduce regulatory burden and costs. (DP p38)*

##### Council of Ambulance Authorities

*A National approach to assessment may be advantageous to ‘harmonising’ processes ... A ‘centralised’ national policy approach and support is desirable. (DP p10)*

##### Pharmaceutical Society of Australia

*The pharmacy accreditation authority, APC, already possess the necessary expertise in assessing local programs to ensure work-ready graduates so it is PSA’s view that they should be assigned the function and responsibility to assess overseas trained practitioners. (DP p12)*

##### Australian Dental Association

*Assessment of Overseas Qualified Dentists is currently done by the ADC on behalf of the Dental Board of Australia and the ADA supports no change. (DP p13)*

##### Psychology Board of Australia

*Individuals from overseas apply to the Board to register in Australia, making the registration board an appropriate entity to assess their application including their training, qualifications, skills, experience and suitability for practice, in a “one-stop-shop” assessment for fitness to practice. This streamlines the process and reduces the costs for individuals as there is a single assessment fee. Assessment of qualifications by an accreditation council creates a duplicate and more costly process, as a separate assessment would then need to be conducted by the Board for the purposes of registration, leading to double-handling and increased cost and delays. (DP p5)*

As part of the development of a one-step approach, the respective entities will need to review the criteria for assessment of overseas trained practitioners for the purposes of registration and for skilled migration to address anomalies, reduce duplication and enable a consistent approach. The Review considers that there will continue to be elements of the assessment process that remain profession specific, however, where they remain different for those purposes, the reasons for these should be transparent. Based on the information provided to this Review and its own examination of the issues, it is considered that a one-step approach could be achieved in the short term.

## Setting requirements for supervised practice

National Boards have the capacity to set additional conditions that require registered practitioners to work under supervision to further demonstrate their competence. Conditions can be established for Australian-trained practitioners (new graduates and registrants who have been subject to complaints or notifications processes) as well as overseas trained practitioners. As discussed in Chapter 5, most professions achieve registration upon the attainment of a recognised qualification from an accredited education provider or program of study. The attainment of the recognised qualification is accepted as evidence of the practitioner's knowledge and clinical skills for the purposes of registration in Australia. However, domestic pharmacy, medical and psychology graduates (of four and five-year degree programs) are also required to undertake a period of supervised practice (commonly referred to as an 'internship') prior to general registration.

In the case of overseas practitioners, it is often unclear whether the setting of supervised practice requirements with restricted registration is due to a need to learn or demonstrate competence or to obtain general experience and familiarisation with the Australian health system. As with Australian trained practitioners, employers also have responsibility for orienting overseas trained practitioners with the local processes, such as codes of conduct and government funding requirements (for example, the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme).

ANMAC questioned whether supervised practice for overseas trained practitioners was a valid requirement for general registration in its submission to the Discussion Paper and advised:

*"ANMAC questions the need for periods of supervised practice for overseas educated nurses and midwives. Robust standards and assessment processes should be the basis on which registration is gained. Supervised practice is generally a post-registration treatment rather than a pre-registration requirement". (DP p14)*

The HPACF expanded on the reasons for supervised practice as a requirement for general registration in its submission to the Discussion Paper:

*"The supervised practice requirement in some professions has been implemented in recognition of the fact that the available screening processes do not cover all aspects of performance critical to safe practice. In these cases, supervised practice provides not only a means of comprehensive assessment, but also a way to facilitate integration". (DP p27)*

Curtin University highlighted potential opportunities to the broader health and education sector from a more consistent approach to the assessment of overseas trained practitioners for the purpose of general registration. It noted:

*"Greater consistency in assessment pathways affords opportunities for system efficiency and cross-professional collaboration, while simplifying and demystifying this process for health care practitioners. It may also offer opportunities for higher education providers to develop educational programs to facilitate the transition of internationally qualified practitioners into the workforce". (DP p8)*

The ability to practise under supervision can be useful for overseas trained practitioners as they transition to working in the Australian health system. However, as highlighted in Chapter 5, when setting requirements for supervised practice, National Boards should provide clear guidance on the competencies to be acquired and differentiate these from progressive work experience and ongoing professional development expectations.

## Recommendations

25. AHPRA, in partnership with the national health education accreditation body, health profession accreditation bodies and National Boards, should lead discussions with the Department of Education and Training and the Department of Immigration and Border Protection to develop a one-step approach to the assessment of overseas trained practitioners for the purposes of skilled migration and registration and pursue other opportunities to improve system efficiencies.
26. The national health education accreditation body, in collaboration with National Boards, health profession accreditation bodies and specialist colleges, and other stakeholders should establish policies and guidelines for:
  - a. international course accreditation
  - b. qualification assessments and supervised practice requirements for overseas trained practitioners, aligned with Australian trained practitioner knowledge, skills and professional attributes requirements.

## Specialist colleges and postgraduate medical councils

### Specialist colleges

This Review has examined the level of guidance and oversight provided in the conduct of the accreditation, education and assessment functions of specialist colleges. While the Review focuses its comments on specialist medical colleges, the issues raised also apply to specialist colleges in dentistry and podiatry.

As part of recognition under the National Law, requirements for the accreditation of programs of study and education providers were established for specialist registration. Prior to the introduction of the National Law, the Commonwealth Minister for Health and Ageing had the power to recognise a new medical specialty or sub-specialty and, if necessary, approve an amendment to the [Health Insurance Regulations 1975](#). The first component of this recognition was for organisations that wanted to have specialist medical skills and knowledge acknowledged and accepted as the standard for a particular area of practice. This form of recognition had no legal status, but had a clear impact on approaches to health care delivery. The second component enabled doctors with specific qualifications to attract a relevant Medicare benefit for services rendered.

In July 2010, accreditation of specialist medical education and training programs became mandatory under the National Law for the purposes of specialist registration and provided for the protection of specialist titles. This was an important privilege, as specialist titles were not previously protected. The professions of medicine, podiatry and dentistry now have specialist registration categories.

The decision to recognise specialist titles for registration purposes now rests with the Ministerial Council, which has issued guidance on the recognition of specialities under the National Law. However, Ministerial Council decisions do not impact on eligibility for Commonwealth benefit programs such as the Medicare Benefits Schedule or the Pharmaceutical Benefits Schedule. Eligibility for these programs comes under separate Commonwealth Government application and assessment processes.

There are 13 specialist categories within dentistry, one specialist category in podiatry and 23 specialist categories (and 63 fields of specialty practice) in medicine. The full list of specialist categories is available on the AHPRA [website](#). Each respective National Board has established a registration standard that governs specialist registration. As outlined in Chapter 2, current accreditation and assessment processes for specialist colleges:

- endorse the specialist college as an approved **education provider** for the purposes of specialist registration
- empower the specialist college as an **accreditation authority** with the mandate to establish specialty-specific accreditation standards
- authorise specialist colleges to undertake **assessments of overseas trained specialists**.

Specialist medical colleges undertake all three accreditation and assessment functions outlined above. Dental and Podiatry specialist colleges are approved education providers and can also undertake assessments of overseas trained specialists at the request of the respective National Boards. AHPRA and National Boards advise that the podiatry and dental specialist colleges are not involved in the accreditation of training sites or individual training posts.

The range of approved specialist training programs includes:

- **Dentistry:** Three-year Doctorate programs delivered by universities across the range of specialties or five-year Fellowship programs delivered by specialist colleges.
- **Podiatry:** Three-year Doctorate program in podiatric surgery from the University of Western Australia or three-year Fellowship of the Australasian College of Podiatric Surgeons.
- **Medicine:** Fellowship programs ranging from three to six years across various specialties delivered by specialist colleges.

While the dental and podiatry specialist registrations can be obtained through programs of study delivered through universities, the specialist medical program is delivered entirely by specialist medical colleges. The ADC in its submission to the Discussion Paper summarises the key difference in its approach:

*“The arrangements for dental specialist accreditation is very different to medical accreditation, and is delivered both through universities and specialist Colleges, usually as a Doctor of Clinical Dentistry (DClinDent) qualification. The ADC accreditation standard is the same across all dental programs encompassing entry to practice programs to specialist programs. This means that the ADC is less concerned with the type of education provider delivering the program and more focussed on the graduate outcomes. This allows an open market for the delivery of specialist education in dentistry and enables innovation in the way a program is delivered”. (DP p36)*

The accreditation processes for approval of specialist programs of study and education providers is different for specialist colleges and universities. Specialist college programs are not required to comply with the Higher Education Threshold Standards as compliance does not lead to an award within the Australian Qualifications Framework (AQF).

The AMC undertakes a periodic review of the specialist medical colleges in the exercise of its accreditation and education functions. Each specialist college is assessed against the [AMC Standards](#) for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs (‘the AMC Standards’), which were approved by the Medical Board and came into effect on 1 January 2016. The accreditation process is guided by the 2017 [AMC Procedures](#) for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs’. Periodic reviews are supplemented with annual reporting by each specialist college. While information on the outcomes of accreditation reviews undertaken by the AMC is available on its [website](#), the annual reports from respective specialist colleges are not available.

With regard to the role of the specialist college as a ‘sub’-accreditation authority (with the ability to set accreditation standards and assess training sites), the AMC Standards include guidance on specialist college interactions with the health sector (including training sites) and the expected outcomes of specialist education training. While the AMC accredits specialist medical colleges against the same standard, each specialist college has established its own discipline-specific accreditation standards against which it assesses its training providers.

Following concerns raised by health services in a number of jurisdictions about duplication across specialist medical college assessment processes, in 2012 AHMAC commissioned the *Accreditation of Specialist Medical Training Sites Project*, led by NSW Health. The final phase was undertaken in partnership with the Council of Presidents of Medical Colleges (CPMC) to finalise agreed domains, standards and criteria for accreditation of training sites. The project highlighted the significant levels of duplication in accreditation processes and recommended a number of changes, including consistent accreditation cycles, coordinated site visits, joint training of assessors and agreement on common evidence requirements. The project’s final report includes a National Accreditation Framework for Medical Specialty Training and [domains and standards](#) to be used by all colleges. Three common domains and corresponding standards were identified and agreement was reached with the CPMC that all colleges would include these domains in accreditation standards. Beyond these agreed domains, colleges still retained the ability to establish additional domains and standards with evidence requirements that were specific to its specialty/sub-speciality.

The Review understands that timelines for implementation of these recommendations were not set. However, there is an expectation that, as specialist medical colleges review their respective accreditation standards, they will incorporate the agreed domains and standards to the assessment of training sites. Five years after the AHMAC Project was commissioned, there is no requirement for the CPMC or AMC to report on the number of colleges that have incorporated these domains within their accreditation standards. Given the significant work to identify and streamline the common elements of specialist college assessment processes to minimise cost, duplication and improve transparency, the Review considers there should be a more proactive approach by the AMC to ensure implementation of the agreed domains and standards as part of its accreditation of specialist medical colleges.

In addition to the lack of consistent and common approaches to specialist accreditation highlighted by the AHMAC Project, this Review notes that there are additional gaps in the level of AMC oversight of specialist colleges. Standard 2.2.1 of the AMC Standards state:

*“The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice”.* (p6)

The AMC Standards also note that *“Accreditation is awarded to the education provider for the specific medical program, identified by its award title and recognised specialty and field of specialty practice (in Australia)”*. (p5) A review of accreditation reports undertaken by the Review confirms that periodic assessments for the purposes of accreditation of specialist colleges as education providers only include assessments of some sub-specialty programs of study.

Although the assessments are designed to capture the functions of the specialist medical colleges and related subspecialty societies as education providers, they do not consistently include assessment of their roles in accreditation of training sites. Colleges have their own standards for the accreditation of training sites. The RACP [Standards for the Accreditation of Training Settings](#) is high level and comprises five standards, including supervision and infrastructure requirements. The RACP has [additional sub-accreditation criteria](#) to guide the accreditation of subspecialty training programs, which detail the requirements for accreditation of training sites. RACS also has established criteria, as well as further sub-accreditation criteria that are specific to its subspecialties, however, the sub-criteria are not publicly available. The role of the AMC in monitoring the respective sub-accreditation criteria that govern subspecialty accreditation of training sites is also not clear. The AMC accreditation reports focus on the role of the specialist college more broadly and do not consistently include assessments of the efficacy of sub-accreditation criteria.

There is a complex sub-accreditation process for subspecialties (including the 63 fields of specialty practice referred to within the specialist registration standard). The Review notes that this issue was recognised by the AMC in its [assessment of RACS](#) in 2007:

*“There are clear differences across the nine surgical training programs. While these may be appropriately related to intrinsic differences in the practice of surgery in the surgical specialties the Team urges the College to work towards common standards when these are sensible and achievable. Differences should be defensible and the reasons for them clearly explained”.* (p2)

The AMC also noted in a recent [assessment](#) of the Royal Australasian College of Pathologists conducted in 2016:

*“The training in and assessment of the non-technical competencies appears to be variable across disciplines and sites...”*. (p82)

This is further complicated as, in some cases, the accreditation of training sites is not undertaken by the specialist medical college but by a specialist society. This issue came to the fore recently when the [Sunshine Coast University Hospital](#) failed to meet accreditation criteria for orthopaedic surgery. The accreditation of orthopaedic surgery is undertaken by the [Australian Orthopaedic Association](#) (AOA), which is the peak professional organisation for orthopaedic surgery in Australia. RACS assigned this function to the AOA. RACS has also assigned the accreditation of general surgery, neurosurgery, otolaryngology head and neck surgery and urology to speciality societies and associations. This raises the question of whether those professional bodies are subject to the same standards of transparency, cost-effectiveness and accountability expected of other health profession accreditation bodies undertaking a monopoly function under the National Law. [Concerns](#) about the perceived influence of specialist colleges in controlling both the domestic supply of specialists (through the accreditation of training sites and posts) and the overseas supply (through assessments of overseas trained specialists) continue to be raised from time to time.



The AMC assessment report for RACS is silent on whether its assessment processes include investigation of the accreditation processes of all of the respective professional associations. The Review is concerned that, when sub-accreditation authorities (specialist medical colleges) assign functions to other professional associations, the level of accountability to the National Scheme and the National Law is further removed. As highlighted by a submission from a medical practitioner to the Draft Report:

*“The accreditation of postgraduate training by doctors in the same craft group which is being accredited imposes an insurmountable conflict of interest for the specialist colleges”.* (Individual submission 1, p1)

The Review considers that any organisation that undertakes such functions should be subject to the same standards of efficiency, accountability, public scrutiny and cost-effectiveness as other entities. This applies to all processes, including the establishment of accreditation standards, assessment processes, setting fees and charges, grievances and appeals processes and monitoring and reporting requirements. Accreditation processes should also be reviewed and updated periodically to ensure they remain fit for purpose and aligned with contemporary health practice. All activities related to the accreditation, education and assessment functions should be documented, publicly available and subject to monitoring and assessment.

### *Assessment of overseas trained specialists*

Medical and podiatry specialist colleges also undertake assessments of overseas trained specialists. The Podiatry Board of Australia in correspondence to this Review has advised:

*“The arrangements with the college will cease once the Board in conjunction with ANZPAC has developed an alternative assessment process. The timeline for this project is dependent on the development of competencies for podiatric surgeons, and this work is well underway. Due to the complexity of the work, interrelated projects, and the need for transitional arrangements, at this stage the work is expected to be substantially completed in 2018”.*

Unlike dentistry and podiatry (which also have specialist training programs delivered by universities), the Medical Board [registration standard](#) (2011) established eligibility for ‘Fellowship’ of a specialist medical college as the only approved qualification for the purposes of specialist registration. The registration standard makes clear the difference between being a Fellow of the college versus eligibility for Fellowship and the National Board, in its response to the Discussion Paper advised:

*“... the Board will accept for specialist registration confirmation that an applicant has been assessed by a specialist college and has passed the requirements for the approved qualifications, regardless of whether they have been awarded a fellowship. It is not necessary for medical practitioners with specialist registration to continue to be members or fellows of the specialist college to remain on the Specialists Register. Fellowship in this context does not refer to the qualification (which cannot be revoked), but to the ongoing affiliation with or membership of the specialist college. However, medical practitioners on the Specialists Register are required to continue to comply with the Board’s registration standard for CPD. In the case of medical practitioners on the Specialists Register, this requires that they meet the standards for CPD set by the relevant AMC accredited specialist college”.* (DP p2)

Whilst the Medical Board is clear, specialist medical college websites do not advise applicants for specialist registration that it is not necessary to continue to be a member or fellow of the specialist college to remain on the Specialists Register. This oversight was acknowledged by the CPMC in its submission to the Draft Report:

*“The Review misunderstands the registration process where there is one pathway to specialist registration and the other is in fact a training program. However, it is acknowledged that the depth of information on websites may warrant improvement”.* (DR p2)

Given the importance of separating the meeting of requirements for the approved qualifications for registration purposes and the decision to seek membership of a private organisation, the Review considers that colleges should explicitly ensure that the necessary information is made available to all prospective candidates.

The Medical Board of Australia authorises specialist medical colleges to conduct assessments of overseas training specialists through an exchange of letters. In those letters, the Board advises that the National Law indemnifies the college from liability for “anything done or omitted to be done in good faith in the exercise of this function under the National Law” (s236) and any liability is borne by AHPRA and not the college (s236(2)).

In that correspondence, the Medical Board also advises that the AMC “will not have a role” in the assessment of overseas trained practitioners. However, the Medical Board goes on to state that the “College will provide advice to the National Board on the results of the assessment by providing that advice to the AMC”.



Given the AMC is responsible for accrediting the specialist medical colleges in the first place, these reporting and accountability mechanisms are confusing and the role of AMC unclear. The MBA as part of the joint AHPRA and National Boards submission to the Draft Report sought to clarify its decision:

*“Removing the requirement for IMGs to apply for a specialist assessment via the AMC has reduced unnecessary steps and duplication and improved timeliness and communication. The IMG assessment is a registration function, not an accreditation function. Under Section 59 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law), the Board can require an individual to undertake an examination or assessment to assess the individual’s ability to competently and safely practise the specialty. AHPRA, on behalf of the Medical Board, has appointed the AMC accredited specialist medical colleges to conduct this examination or assessment”.* (DR p26)

As outlined in Chapter 6, the Review sees no reason why accreditation authorities (including sub-accreditation authorities) do not have the necessary expertise to undertake these assessments of overseas trained specialists. Given the role of the AMC in accrediting specialist colleges, it should also have the responsibility for monitoring and overseeing specialist colleges in the exercise of their accreditation and assessment functions.

The Medical Board of Australia (2015) issued [Good practice guidelines](#) for the specialist international medical graduate assessment process (the Guidelines) to support specialist medical colleges in their role of assessing specialist international medical graduates (IMGs). The Guidelines came into effect on 2 November 2015 and refer to the [National Specialist IMG Committee](#) whose Terms of Reference includes reviewing the operation, monitoring and reporting on the assessment of specialist IMGs (p3). Based on the information available on the Medical Board of Australia website, records of meetings of that committee have not been published since 2013 and any necessary information is provided through the Board’s monthly updates. The latest published [report](#) on overseas practitioner assessments also states:

*“On 1 July 2014 changes were made to the specialist pathway for IMGs. IMGs now apply directly to the relevant specialist medical college for assessment rather than through the Australian Medical Council (AMC). The AMC previously collected a range of data on specialist pathway applications. As the AMC no longer collect pathway data, colleges now report their data directly to the Board”.* (p1)

The agreements involving the Board, AMC and specialist medical colleges do not specify how assessment, accreditation and monitoring in relation to overseas practitioners will occur. AHPRA advised the Review:

*“The AMC provides the MBA with a comprehensive report on each specialist college that it reviews and accredits. The report assesses colleges against all of the accreditation domains in the accreditation standards. In addition to the comprehensive report (which can be more than 100 pages), the Chair of the Specialist Education Accreditation Committee attends the meeting of the MBA to provide any additional information and to answer questions. The AMC monitors specialist colleges via the accreditation function and provides the MBA with regular monitoring reports of each specialist college”.*

Specialist medical colleges and the Medical Board report on different items over different time periods, making it difficult to draw any conclusions on the assessment pathway to registration as a medical specialist. Other key areas of interest such as the number, patterns and reasons for application withdrawals, are not detailed and no information is provided on the outcome of appeals.

The 2014 NRAS Review also recommended that the Medical Board evaluate and report on the performance of specialist medical colleges in the assessment of overseas trained specialists and establish performance benchmarks for completion of these assessments. The Medical Board in its submission to the Discussion Paper highlighted:

*“Following the Snowball review, the Board started collecting performance data annually from all the specialist colleges in relation to their assessment of specialist international medical graduates. The data is published on the Board’s [website](#). In 2016, the Board set specific performance benchmarks in relation to the assessment of specialist international medical graduates. The Board will publish the performance of Colleges against the benchmarks”.* (DP p2)

Noting the proposed evaluation of the performance of specialist colleges, this Review advised it would consider decisions, processes and governance relating to the assignment, monitoring and reporting of functions across the variety of accreditation arrangements and assessment of overseas practitioners but would not consider in detail any international assessments or operations and performance.

The Medical Board advised that it has commissioned an external review of specialist medical colleges (see Appendix 8 for the Terms of Reference). While the work appears able to make recommendations in relation to performance measures set by the Medical Board and its future monitoring of college performance, the task is limited to only consider:

*“The extent to which each college’s processes and procedures comply with the guidance in the ‘Good practice guidelines for the specialist international medical graduate assessment process’ (the Good Practice guidelines)”. (p1)*

The Review considers it would be preferable for the reviewers to be able comment on the adequacy of the Good Practice guidelines themselves, given they were developed by the Medical Board as the best practice benchmark and encompass matters such as roles, fees, assessment criteria and procedures.

Concerns about specialist medical colleges and their assessments of overseas trained specialists were highlighted in the NRAS Review and have been subject to frequent media coverage and a number of government inquiries. In 2012, the Parliament of the Commonwealth of Australia released its [Lost in the Labyrinth](#) - Report on the inquiry into registration processes and support for overseas trained doctors. This Report contained 45 recommendations including:

*“Recommendation 7 - The Committee recommends that the Australian Government Department of Health and Ageing and Australian Medical Council, in consultation with the Joint Standing Committee on Overseas Trained Specialists and the specialist medical colleges: publish agreed definitions of levels of comparability on their websites, for the information of international medical graduates (IMGs) applying for specialist registration; develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are used to determine level of comparability; develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are taken into account when determining the length of time an IMG needs to spend under peer review; and develop and maintain a public dataset detailing the country of origin of specialist pathway IMGs’ professional qualifications and rates of success”. (p xxi)*

Specialist colleges derive a direct benefit from the introduction of protected specialist titles and are protected from liability under the National Law for their accreditation and assessment functions. The National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) submitted:

*“In the past, the NHPOPC has been approached by overseas trained practitioners who are dissatisfied with the assessment process undertaken by the relevant accreditation authority. This group of complainants often raise concerns about delays in the assessment process, what they perceive to be unfair outcomes, and the cost of the assessment process. The NHPOPC does not, however, currently have jurisdiction to assist people who raise concerns regarding the administrative actions of an accreditation authority and this has been a source of frustration to a number of people who have contacted the NHPOPC. Based on this, amendments to the assessment process for overseas trained practitioners, including the introduction of an independent complaint handling mechanism, would be an important improvement”. (DR p8)*

The Review considers that it is time to look beyond immediate performance issues and consider a model that provides governments and the public with the confidence that arrangements are robust and transparent and that systems are able to monitor and respond to issues as they arise and ensure continuous improvement going forward. Accreditation and assessment activities undertaken by specialist colleges within the National Scheme are similar to those being undertaken by the 14 current accreditation authorities (and the education providers). Therefore, all recommendations relating to efficiency, transparency and governance applying to health profession accreditation bodies should also apply to specialist medical and podiatry colleges.

## Postgraduate medical councils

The medical, pharmacy and podiatry National Boards have introduced a category of registration that requires all graduates of approved programs of study to undertake a period of supervised practice, commonly known as internship. Medicine (and pharmacy to a lesser extent) has established accreditation processes to guide the implementation of supervised practice programs. This is detailed in Chapter 5.

The medical internship program has been designed in a similar manner to specialist training programs. The AMC accredits postgraduate medical councils (PMCs) against [National Standards](#) and the PMCs accredit intern training sites and establish and oversee educational activities and programs for prevocational doctors with hospitals and practices. Upon achieving AMC accreditation, a PMC is granted the authority to accredit intern training programs and posts in its state or territory. Successful completion of an internship is a prerequisite for general registration. Accreditation of intern posts is mandatory and undertaken in accordance with the Granting general registration

as a medical practitioner to Australian and New Zealand medical graduates on completion of [intern training standard](#). As noted in Chapter 3, the MBA directly funds via agreement the PMCs to undertake this process and they also receive funding from state and territory health departments for activities including broader education and training of all prevocational trainees.

The Medical Board and the AMC have established a national process that enables the development of a consistent approach to medical intern training nationally and this is a very positive advancement. Submissions to the Review on PMCs were limited and, where provided, were largely supportive of existing processes, though several suggested greater clarity.

Box 8.2. Views on the governance of specialist colleges and PMCs

#### **Australian Medical Council**

*Intern training accreditation authorities, generally called Postgraduate Medical Councils, undertake a variety of roles for their state health departments, one of which is accreditation of medical intern training posts and programs. They generally work under a contract or service agreement with their state or territory health department as well as an agreement for service with AHPRA on behalf of the Medical Board of Australia. The accreditation of intern posts and programs is covered by national standards, developed by the AMC on behalf of the Medical Board of Australia. The AMC assesses this work through an accreditation process. (DP p29)*

#### **Australian and New Zealand College of Anaesthetists**

*ANZCA suggests there should be clear delineation of responsibility between the National Boards, specialist colleges and postgraduate medical councils and the relationships between these entities should be more collaborative. There are three principal layers in the Australian and New Zealand medical education systems:*

- *Undergraduate training towards a primary medical degree (overseen by the universities).*
- *Pre-vocational medical education (overseen by the pre-vocational medical councils and AHPRA and the MBA).*
- *Vocational (specialist) medical training (overseen by the postgraduate medical colleges).*

*The AMC has effectively implemented accreditation functions at each of these levels, appropriately tailored to the nature and context of medical training at each level. The AMC governance and committee structure draws representation from each level, and bodies such as Medical Deans Australia and New Zealand, the Council of Presidents of Medical Colleges, and the Confederation of Postgraduate Medical Education Councils provide input on behalf of their members. The AMC and the Medical Board of Australia are well-placed to oversee integration and coordination between these phases of medical training as competency-based medical education evolves and there is increasing recognition of the importance of transitions between these phases. (DP p11)*

#### **Department of Health and Human Services Victoria**

*DHHS considers the multi-layered arrangements do not provide sufficient scrutiny of these functions - in particular the outcomes achieved and opportunity costs. Further research and evaluation is needed on the costs and benefits of the current approach, focusing on both training providers and health services. (DP p12)*

#### **Faculty of Pharmacy, University of Sydney**

*To our knowledge the National Law does not explain these arrangements. We have no experience of this but from a distance it would appear to be a non-transparent arrangement and should be opened up for greater public scrutiny to ensure that is not anti-competitive and is in the best interests of public safety. (DP p9)*

The Medical Board advised the Review that intern training was not an accreditation function under the National Law and thus out of scope. The Review considers that, while the medical internship program has been established as a provisional registration standard, internships are education and training programs and delivery is aligned with curricula, and successful completion is necessary for progression to general registration.

As with specialist colleges, the Review's concern is the extent to which the standards developed by PMCs and their assessment processes are subject to scrutiny. The COAG Agreement guarantees medical internships for all domestic graduates. Given this significant public investment, it is important that processes governing the establishment and implementation of the education and training program also meet the public defensibility test of transparency, efficiency and cost-effectiveness.

## Recommendations

27. The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners. This includes working in partnership with the Medical Board of Australia on the development of agreed performance indicators and reporting metrics that are appropriate, comparable and aligned with other relevant National Scheme reporting regimes, in terms of time periods, cost effectiveness and the ability to trace assessment pathways from application to registration.

28. Specialist colleges should ensure that the two pathways to specialist registration, namely:

- being assessed by a specialist college and passing the requirements for the approved qualification, or
- being awarded a fellowship of a specialist college

are documented, available and published on specialist college websites and the necessary information is made available to all prospective candidates.

## Grievances and appeals

The 2014 NRAS Review observed that accreditation councils have varying structures and fee-setting methods and that there was little recourse in the National Scheme to appeal their decision-making processes.

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 appeal responsibilities of accreditation authorities as follows:

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

- *directly relates to an accreditation function under the National Law*
- *is an issue that should be considered in the accreditation entity's monitoring processes under Section 50 of the National Law.*
- *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”.*

Submissions in relation to the guidance document were limited and focused on the current accreditation councils' grievance and appeals processes (see Box 8.3). Generally, stakeholders held the view that systems would benefit from some form of independent review process. The NHPOPC or a similar body was considered the most appropriate entity to undertake this function, although some submissions suggested there should be capacity for merit reviews, enabling a decision to be overruled and a new one made by an appeals entity.

## Box 8.3. Views on grievances and appeals

**Occupational Therapy Council (Australia and New Zealand)**

*The OTC believes the current system works well. However, if a change in that system were to occur, the OTC believes the external appeal facility should be with a body akin to the National Health Practitioner Ombudsman or be a separate system. However, the cost of such an external body should be carefully considered before implemented. (DP p20)*

**Australian Dental Council**

*The ADC does not have an opinion whether an existing entity is appropriate for this role; however, any entity must have the appropriate skills and knowledge of the scope of the complaints it is empowered to deliberate on. This may also include fees and charges if the entity is equipped to adjudicate on such matters. (DP p38)*

**Health Professions Accreditation Collaborative Forum**

*One of the strengths of the NRAS is the independence of accreditation entities (with reporting and accountability requirements). That means that they are able to make decisions free of undue influence of stakeholders such as the professions, national boards, and education providers. If there is to be a complaints mechanism external to the accreditation entities then it either has to be an entity akin to the National Health Practitioner Ombudsman (NHPO), or a separate system (which is just another cost). (DP p28)*

**Australasian Osteopathic Accreditation Council**

*AOAC supports the need for robust review of the decisions made by accreditation authorities and utilises an approach to appeals from education providers regarding decisions which emphasises the independence of the appeal process. AOAC has not received any appeals regarding its accreditation process to date. This may be because of the open channels of communication between education providers and AOAC.... If an external entity is considered necessary AOAC supports the National Health Practitioner Ombudsman as an appropriate channel for grievances and appeals. AOAC further supports the scope of complaints to encompass all accreditation functions including fees and charges. (DP p19)*

**Australian Medical Council**

*In general the AMC agrees that a channel outside the accreditation authorities for unresolved complaints and grievances is a reasonable point, depending on the scope of the complaint.... If there is to be a complaints mechanism external to the accreditation entities then it either has to be something like the National Health Practitioner Ombudsman, (NHPO) which is not really independent of the main NRAS players or a separate system which is another cost. The Forum collectively might provide this channel at reasonable cost. (DP p31)*

**CQUniversity**

*Mechanisms for lodging complaints with NRAS accreditation authorities are currently inadequate. Mechanisms vary across accreditation authorities and an appeal of an accreditation decision to the accreditation authority generally constitutes the only avenue for appeal ... There appears to be no mechanisms to appeal the decision of National Boards regarding decisions on the approval of programs since a search on the AHPRA website for National Boards does not provide any options for appeals regarding program approval decision, only information on individual practitioner registration appeals.*

*There is therefore a need for an external appeal mechanism for adverse decisions regarding the accreditation and approval of a program. The NRAS appeal mechanism should operate in a similar manner to appeal mechanisms in place for TEQSA whereby there is an initial internal appeal mechanism. In the event of dissatisfaction with the internal appeal TEQSA providers may appeal to the Administrative Appeals Tribunal (AAT) for reconsideration of the decision. A similar, legally binding external appeal mechanism should be available to education providers under the NRAS scheme where providers believe a decision has been made that is inconsistent with the intent and meaning of the applicable accreditation standard. (DP p11)*

**Australian Council of Deans of Health Sciences**

*ACDHS members assert there should be a formal appeal process where all matters are dealt with in a transparent manner by an independent arbiter. (DP p28)*

The NHPOPC considered that there are inadequacies with the current AHPRA/HPACF guidelines:

*“While the Guidance Document provides some explanation of the processes applicable to accreditation-relation complaints, it tends to focus on situations where complaints are made to accreditation authorities about accredited programs of study or an education provider. The Guidance Document does not comprehensively address all situations where complaints about accreditation-related matters may arise, particularly in relation to complaints about accreditation authorities themselves (for example, complaints about the process for assessment of overseas trained health practitioners seeking registration in Australia). In this regard, there is a lack of clarity about the management of the full range of accreditation-related complaints”. (DP p11)*

Submissions to the Draft Report were generally in support of such a review capacity, although the HPACF stated:

*“The Forum questions whether it makes sense, in terms of regulatory efficiency, to add another type of complaint from educational institutions for the NHPOPC to handle in the absence of a clear and demonstrated problem with the existing mechanisms. On this basis the Forum also questions the need for a NHPOPC review of grievances and appeals processes. It would seem to be a costly and potentially time-consuming procedure for a system that has not been found to have problems in the past”. (DR p19)*

The Review, however, considers it important that all National Law accreditation functions should be subject to the requirements specified under the Health Practitioner Regulation National Law Regulation.

Another issue raised in some submissions was the conduct of a review “on the merits”, where a body will look again at a decision and substitute its own decision for the decision originally made. However, the Review considers it would be inappropriate to establish a separate body with the powers to make new decisions, given the need to rely on specialised knowledge and given that current accreditation authorities all have in place appeals models with that capability. The NHPOPC confirmed in its submission to the Draft Report its support for expanding its remit in this area with a scope consistent with that expected of an ombudsman:

*“...the proposed complaint mechanism would not involve merits-based reviews of decisions, but would instead involve conducting investigations into the administrative actions of the relevant accreditation entities. This means that the NHPOPC would not have the power to change a decision made by an accreditation entity, but could make recommendations or suggestions if any areas of concern were identified in relation to the administrative actions of that entity. This complaint mechanism would operate as an important accountability mechanism for the accreditation system”. (DR p9)*

As per the [NHPOPC's website](#), this would mean that the Ombudsman would conduct investigations into the administrative actions of accreditation entities and either:

- determine that the actions were reasonable and take no further action
- provide (or recommend that the relevant body provide) a better explanation of the decision or process
- expedite delayed action
- recommend that an apology be offered
- recommend that processes or policies be reviewed or changed
- recommend that a decision be reconsidered.

This would be consistent with other grievance review arrangements and could be achieved through the Review’s proposal to place the accreditation functions under the Health Practitioner Regulation National Law Regulation, meaning the model should apply to any decisions made by:

- Accreditation Committees in relation to programs of study
- PMCs and specialist colleges in relation to the accreditation of training posts and sites
- any designated entity exercising an accreditation function regarding an assessment of the qualifications of an overseas practitioner (including specialist colleges).

In relation to the application of the FOI, a few submissions raised concerns that access to supporting working documents may compromise accreditation authorities with the Australian Dental Council explaining that their concerns were *“...due to the nature of decisions usually made by specialist colleges and accreditation authorities being based on confidential information; including examination materials and other internal intellectual property which would devalue once in the public domain”. (DP p23)*



The Review is not commenting on the existing intellectual property arrangements in relation to such materials, however, in discussion with the NHPOPC, that office considered that such material would most likely fall under s47C of the Freedom of Information 2002 as “deliberative matter” and considered conditionally exempt. Regardless either way, the Review would expect the exemption or otherwise of any particular types of material could be considered as part of the process of amending the *Health Practitioner Regulation National Law Regulation*.

If the Review’s proposed operational separation of the professional accreditation and institutional academic accreditation functions were implemented, this would permit academic accreditation to be subject to the TEQSA and ASQA established processes. In relation to fees and charges, the Review considers that a structured system-wide response to fee setting, as proposed in Recommendation 1, would be more appropriate.

Given the Review has not had the resources to investigate the appeals processes for every accreditation authority (including specialist medical colleges and post graduate medical councils), it would be worthwhile for the NHPOPC to conduct a systematic review of the HPACF’s guidance document and each relevant entity’s appeals processes, with the view to making recommendations for improvement by each entity where those processes are considered deficient. This should include advice on the implementation of consistent public reporting on the numbers and outcomes of appeals. The Ministerial Council and stakeholders would be provided with confidence that the systems in place are fair and transparent and are commensurate with general expectations of any entity exercising statutory functions.

Discussions with the NHPOPC Office confirm that these additional functions will require:

- 1 EFT to expand the Ombudsman, FOI and Privacy functions of the NHPOPC to include accreditation and assessment functions under the National Law
- 1EFT for 12 months for the NHPOPC to undertake a systematic review of existing grievance and appeals processes across all accreditation entities.

Based on the AHPRA staffing cost model, the Review estimates this would equate to a total cost of \$250,000 for the first 12 months, reducing to \$125,000 on a per annum basis. In line with the principle of cost recovery supported in the Report, funding for the ongoing function should be derived from assessment fees charged and incorporated into the development of funding principles as outlined in Recommendation 1. Given appeals processes are part of core accreditation functions, it would be expected the project funding for the review of grievance systems could be sourced from within the existing AHPRA budget processes.

## Recommendations

29. Accreditation entities and their functions should be subject to the same requirements as all other decision-making entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner in reviewing administrative actions relating to:
  - a. health profession accreditation bodies in relation to programs of study and education providers of those programs
  - b. postgraduate medical councils and specialist colleges in relation to the accreditation of training posts/sites
  - c. any designated entity undertaking an assessment of the qualifications of an overseas trained practitioner (including specialist colleges).
30. The National Health Practitioner Ombudsman and Privacy Commissioner should review the grievances and appeals processes of entities as defined in Recommendation 29, with the view to making recommendations for improvement by each entity where it considers the processes to be deficient.

## Setting national reform priorities

### Government directions

A key issue identified by the Review is the paucity of guidance for governance bodies in the National Scheme on health workforce and system priorities. This Report's Terms of Reference focus on the accreditation system within the National Scheme, however, there is little to be gained in setting a strategic direction for the accreditation entities if that direction is not shared by the National Boards, AHPRA and AManC – let alone by education providers, professional associations, employers and consumers.

Several stakeholders involved in accreditation have stated that while it is not their responsibility to set the priorities, they could more effectively respond if there were better arrangements in place to advise them of those priorities. A similar conclusion was 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 (AHMAC) 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”. (p44)*

Section 19 of the National Law provides one possible mechanism – the establishment of an Australian Health Workforce Advisory Council (AHWAC):

- (1) *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.*

Although this body remains on the statute book within the National Law, it is not used. The decision on the future of AHWAC was referred to the 2014 NRAS Review for advice. It recommended that a new body be established (to be known as the Professional Standards Advisory Council) to advise the Ministerial Council on key matters of interest in the performance of the National Scheme. The Ministerial Council, in response, accepted that improvements to governance, reporting and reform arrangements are necessary, but determined that this should be achieved through existing structures.

The Ministerial Council is also empowered to provide a range of advice and directions to the National Scheme. Section 11 of the National Law provides:

- 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.*

The statutory provisions of the National Law provide a general power of direction to the Ministerial Council about the policies to be applied by AHPRA and National Boards in exercising their functions. It is less usual, however, to enable directions to be made on matters such as standards issued by a regulatory body, and for the Ministerial powers to be restricted in the form provided under s11(4).

It is important to understand the context in which governments created a single health workforce regulatory scheme that resulted in 14 separate independent National Boards being individually responsible for regulation of the registration and accreditation of their respective professions. Prior to the establishment of the National Scheme, a number of functions had been traditionally run by the professions, enabling them to direct crucial areas such as competency standards, scopes of practice and professional boundaries, workforce interdependencies, and education and training regimes. All of these functions can have a significant impact on the delivery of health care, service access, service configuration, payment regimes and the like. Health systems and governments have had to respond to disputes between professions over expanding scopes of practice and professional boundary matters in either regulatory schemes or the industrial regime. Such matters continue to arise.

For example, the AMA’s submission referred to the National Law Objectives in relation to the nursing, pharmacy and optometry professions:

*“Further, the AMA is of the view that health practitioner boards are misusing the objectives in paragraph 3(2)(f) of the National Law ... Some boards appear to be applying this objective in the broadest sense, acting as champions of their practitioners and not as protectors of the public, by permitting changes to scopes of practice without any robust assessment of: need; the existence of accredited education and training programs that deliver the required competencies; the risks to patients; the impact on training for and care provided by other practitioners; or the costs to the health care system”. (p2)*

Professional boundary disputes are complex, usually requiring an assessment of claims of threats to safety and quality. In the absence of an overarching and fully independent entity that can determine where commonality or consistency across professions is appropriate, and where boundary and scopes of practice reforms are necessary, Ministerial Council involvement will continue to be the point of resolution. Often the Ministerial Council is required to be involved in matters that are entirely operational and procedural, as advised by NSW Health in relation to the NRAS Governance Review:

*“One common area is the role of the Ministerial Council in providing oversight of various regulatory instruments generated under the National Scheme. For the governance review, this includes registration standards, codes and guidelines. The NRAS governance review is considering in what circumstances it is appropriate for these instruments to be approved by the Ministerial Council (as is currently the case for registration standards) or by another delegated body. Views have been put forward that the Ministerial Council’s time is being unduly expended on approving instruments (including amendments to instruments) that have no strategic impact in terms of the Scheme’s objectives. Consideration therefore needs to be given to (a) possible delegates in relation to some of these approval powers; (b) bodies responsible for giving advice or guidance to the delegate; and (c) protocols for guiding such delegated approvals.*

*In relation to accreditation standards, this may be relevant if it is anticipated that entities in addition to Boards have some oversight or approval role in regard to accreditation standards, for example if Ministerial approval of accreditation standards were to be mandated. In that case, it may be that the findings from the governance review could also be applicable to accreditation standards". (DR p11)*

The Review has sought to address the resolution of accreditation responsibilities through the proposed governance changes and a proposed cooperative approach to clarifying regulatory responsibilities with TEQSA and ASQA on specific domains within the accreditation standards. Should this change of governance be endorsed, it would be appropriate to remove reference to accreditation standards in the National Law's Ministerial Council directions provisions.

## Development of national workforce policy

There is broad support for a process that provides consistent and regular policy guidance that is acted upon by all entities and processes within, and interdependent with, the National Scheme. Submissions to both the Discussion Paper and Draft Report showed an almost universal agreement on the importance of this, while acknowledging the complexities.

Box 8.4. The need for national policy guidance

### Medical Deans Australia and New Zealand

*There are serious challenges facing the delivery of health services today including an aging population, the increasing burden of chronic disease, new technology, resource allocation and the intersection of Commonwealth State responsibilities. Ensuring a well trained workforce with the right skills in the right places is critical to addressing these issues and will not be achieved without a clear, strategic policy framework, with all stakeholders providing input. (DR p11)*

### Health Professionals Accreditation Collaborative Forum

*Experience in consulting health jurisdictions when accreditation entities are proposing changes to accreditation standards shows that responses from individual jurisdictions may be quite different. While this is not surprising, given Australia's state-based delivery of health services and the different geographic, population and disease profiles, accreditation authorities would welcome discussion about a mechanism that allowed them to navigate these different priorities and responses. (DP p25)*

### Australian Council of Deans of Health Sciences

*ACDHS members are generally supportive of the need for a policy process to identify national health workforce directions and possible reforms listed in recommendation 36. As a collaborative approach between states and the Commonwealth is required, the COAG Health Council may be the body best positioned to provide oversight for such a process. (DR p18)*

### Australian Medical Students' Association

*AMSA supports an approach to health workforce reform which is focused on Australia's future health needs and responsive to changing trends. AMSA believes that recommendation 36 should be implemented, to ensure that workforce meet community needs of Australians. In the case of medicine, the National Medical Training Advisory Network (NMTAN) is well placed to contribute substantially to this in an advisory capacity. Significant investment into the research and implementation of this proposal would need to occur. (DR p12)*

### Joint National Boards/AHPRA

*We agree that clearer identification of health workforce priorities would help National Scheme bodies deliver on the workforce objectives of the National Law. There is currently no nationally articulated workforce reform agenda, which means that National Boards and Accreditation Authorities endeavour to respond to local agendas. We accept that accreditation is seen as a workforce lever but there is often a lack of clarity about how that lever can be used to facilitate workforce reform in a system that regulates by title rather than practice. More guidance from Ministers would be helpful in this regard... We consider a national workforce reform agenda developed in consultation with key stakeholders would be more effective in delivering a national focus and facilitating appropriate regulatory responses from National Scheme bodies. As an interim step, with appropriate support, NRAS bodies could convene regular discussions with stakeholders about workforce reform priorities, in addition to the usual wide-ranging consultation required in the development of accreditation standards. (DP p14)*

## Box 8.4. The need for national policy guidance

**Department of Health and Human Services Victoria**

*DHHS considers there is a need to strengthen the mechanisms through which jurisdictions jointly identify reform priorities concerning the accreditation functions and negotiate and agree performance targets and measures with the agencies of NRAS. The Ministerial Statement of Expectations process that has been implemented in Victoria is a key tool for negotiating priorities for reform and setting performance measures with statutory regulators. Ideally such a process should be occurring on a three-yearly cycle, with annual review. (DP p11)*

**Commonwealth Department of Health**

*The Department welcomes recommendations that strengthen collaboration in both identifying and actioning nationally agreed workforce priorities, noting that relevant work is already under way and will be further supported by changes to the AHMAC structure, including principal committees and reporting arrangements. Regulation and accreditation functions should support, rather than hinder, workforce reform, facilitating inter-professional approaches and ensuring that new practitioners are entering the workforce with appropriate skills to work in evolving health care systems. (DR p11)*

**Monash Health**

*A strong governance model with appropriate representation from all professional groups and service settings would assist in meeting this objective. Monash Health acknowledges the number and complexity of external stakeholders, however if we require the workforce to work in an inter-professional / interdisciplinary manner then the approach at a national level also needs to reflect this. Again the consumer voice in this is critical. (DP p6)*

**Australian Private Hospitals Association and Catholic Health Australia**

*The Australian Government has acknowledged the importance of a strong private sector in the provision of health services. It is therefore essential the private sector also has a voice in the broader workforce reform agenda and the delivery of health workforce accreditation... Current frameworks (e.g. AHMAC and HWPC) are predominantly focused on jurisdictional processes and priorities with limited to no engagement with the private sector, despite the work already being completed there and the additional capacity the sector has to offer. (DP p8)*

**Australian Catholic University**

*ACU believes there is a need for a more holistic approach to the future health workforce. The current, highly uncoordinated approach to the training of Australia's health workforce creates unnecessary costs for universities as well as a broad risk for the community by failing to ensure Australia's future health workforce needs are met.*

*The Organisation for Economic Co-operation and Development (OECD) has observed that Australia is experiencing a substantial expansion of its medical workforce that will improve access to health care but is placing stress on current training capacity.*

*A lack of national vision and coordination is opening up cracks in the quality of the training provided. The escalating costs of clinical placements that are one result of this misalignment impacts universities directly and, ultimately, the health workforce as a whole. (DP p15)*

Most submissions to the Draft Report were strongly supportive of an approach that would enable the development of national workforce policy and directions that

- connects workforce requirements with broader system wide health and social care policies and services that relate to responding to evolving community needs
- engages all stakeholders from the regulators, professions, consumers, service providers and educators.

A strong view advanced by some stakeholders was that AHMAC structures currently have the responsibility and capacity to develop and refine workforce policy and reform priorities. In addition, as part of the COAG Health Council structures, they are considered to be uniquely placed to bring together jurisdictions, regulators and stakeholders in a broad ongoing consultative process that discusses those national reform directions.

In this context, the Productivity Commission's 2005 Report noted that there were many innovations in health care regulation and delivery, but these were often fragmented, poorly evaluated and contested by other stakeholders. The Commission proposed the establishment of a body that would evaluate, publicly report on, recommend and, where appropriate, facilitate health workforce innovation and reform on a national, systematic and timetabled basis. The intent was to create an independent evidence base that policy makers and stakeholders could draw on. COAG's response was to establish Health Workforce Australia (HWA) in 2010. HWA 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 never intended to be a policy formulation body, but nor did it prove to be an independent source of evidence – it required approval for its publications. Notwithstanding this, some of its activities demonstrated the value of a national focus on innovation and workforce reform. During the course of the Review, a number of stakeholders spoke favourably of the contribution made by HWA, though being critical of its governance limitations amongst other matters.

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, while progressively enhancing engagement in this area, have yet to effectively replace the independent evidence-generating capability provided by HWA.

The Review is aware that AHMAC is considering a reconfiguration of its Principal Committee structures. In this context, the Review observes that such arrangements should:

- be integrated into overall national reform processes and directions, given that workforce responsiveness is a critical enabler in progressing health reforms. Reforms encompass multiple domains and within each of these are various levers for policy action that can be used at different levels of the health system. A broad system approach stresses the interconnectedness of strategies and may prevent problems that are more likely to arise with a reductionist focus on a single factor
- effectively engage all stakeholders in consultations, including regulators, professions, consumers, service providers and educators
- be approached in a robust and formalised manner in a regular cycle of policy review to ensure currency and continuous improvement
- draw on evidence from independent, objective and public evaluations of programs and practices.

The dissemination of reform priorities set by governments to National Scheme entities and other regulators and stakeholders should be formalised. As the Review was advised, Victoria has a [statement of expectations framework](#) for statutory regulators and the Australian Government has a similar [model for major portfolio agencies](#).

While the format and configurations vary, and those statements are largely formulated from a Treasury point of view, the model could be tailored to provide a vehicle for the Ministerial Council to issue periodic statements to National Scheme entities (which would be public and available to all stakeholders). Such a process, while respecting the regulators' exercise of their responsibilities under the National Law, could:

- ensure a balanced focus on all National Law objectives
- articulate key health workforce reform directions
- provide greater clarity about policies and objectives relevant to National Scheme entities, including the policies and priorities expected to be observed in conducting their operations
- articulate expectations about the role and responsibilities of National Scheme entities, their relationships with governments, issues of transparency and accountability and operational matters
- establish clear expectations of regulator performance and improvement.



Such an approach would be critical in:

- creating a platform for dialogue between jurisdictions and National Scheme entities
- informing the development of performance indicators, agreed deliverables and outcomes and the capability to effectively monitor progress to promote continuous improvement.

## Recommendations

31. The COAG Health Council should oversight a policy review process to identify national health workforce directions and reform that:

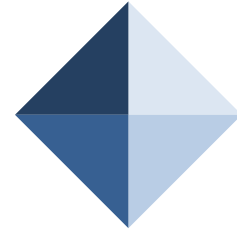
- a. aims to align workforce requirements with broader health and social care policies that respond to evolving community needs
- b. engages regulators, professions, consumers, service providers and educators.
- c. is approached in a robust, formalised and evidence-based manner in a regular cycle to ensure currency and continuous improvement.

32. The Australian Health Workforce Ministerial Council should periodically deliver a Statement of Expectations encompassing all entities within the National Scheme that covers:

- a. key health workforce reform directions, including policies and objectives relevant to entities in the National Scheme
- b. expectations about the role and responsibilities of National Scheme entities, the priorities expected to be observed in conducting operations and their relationships with governments
- c. expectations of regulator performance, improvement, transparency and accountability.

# Appendices

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## Appendix 1: Accreditation recommendations from the 2014 NRAS Review

### Recommendation 1

The Australian Health Workforce Ministerial Council (the Ministerial Council) to establish the Professional Standards Advisory Council (PSAC) for a period of three years to:

- a) facilitate the implementation of accepted recommendations of the Review
- b) establish key performance standards, including financial standards to be reported to the Ministerial Council and individual Health Ministers by National Boards, the Agency Committee, Accrediting Authorities and the Australian Health Practitioner Regulation Agency (AHPRA) in delivering the objectives of the *Health Practitioner Regulation National Law 2009* (the National Law)
- c) inform National Boards, AHPRA and Accreditation Authorities on key health workforce reform priorities and health service access gaps, as identified by Australian Health Minister Advisory Council (AHMAC) standing committee structure and processes, and requiring action by the regulators
- d) examine evidence on contested cross-profession issues that arise from time to time within or between professions
- e) undertake reviews or audits at the direction of Ministerial Council where safety issues or concerns are raised.

### 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.

**Recommendation 24**

The performance of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, in the implementation of changes to the International Medical Graduate assessment process arising out of the Lost in the Labyrinth report, form part of the key performance standards to report to the Australian Health Workforce Ministerial Council.

**Recommendation 25**

The Medical Board of Australia to evaluate and report on the performance of specialist colleges in applying standard assessments of International Medical Graduate applications and apply benchmarks for timeframes for completion of assessments.

## 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 (Australia and New Zealand)  
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.



## Appendix 5: Mapping of accreditation standards

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
Accreditation standards: Aboriginal and Torres Strait Islander health practice Published: December 2013	<ul style="list-style-type: none"> <li>• Education provider and qualification registration</li> <li>• Governance, management, resourcing and infrastructure</li> <li>• Qualification documents and student records</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management, resourcing and infrastructure</li> <li>• Qualification documents and student records</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management, resourcing and infrastructure</li> <li>• Qualification documents and student records</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management, resourcing and infrastructure</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management, resourcing and infrastructure</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management, resourcing and infrastructure</li> <li>• Program attributes</li> </ul>	
Accreditation standards: Chinese medicine Published: December 2013	<ul style="list-style-type: none"> <li>• Education provider and qualification registration</li> <li>• Governance, management and resourcing</li> <li>• Qualification attributes</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management and resourcing</li> <li>• Education provider attributes</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management and resourcing</li> <li>• Program attributes</li> <li>• Qualification attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Program attributes</li> <li>• Professional capabilities of Chinese medicine program graduates</li> </ul>	<ul style="list-style-type: none"> <li>• Education provider attributes</li> <li>• Program attributes</li> <li>• Professional capabilities of Chinese medicine program graduates</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management and resourcing</li> <li>• Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>• Governance, management and resourcing</li> <li>• Program attributes</li> <li>• Professional capabilities of Chinese medicine program graduates</li> </ul>	
Accreditation standards for chiropractic programs Date of effect: 1 January 2018	<ul style="list-style-type: none"> <li>• Public safety</li> </ul>	<ul style="list-style-type: none"> <li>• Governance and quality improvement</li> <li>• Program of study</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• The student experience</li> <li>• Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• Governance and quality improvement</li> <li>• Program of study</li> <li>• The student experience</li> <li>• Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• Program of study</li> <li>• Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• Program of study</li> <li>• Student assessment</li> </ul>	
Accreditation standards for dental practitioner programs Published: December 2014	<ul style="list-style-type: none"> <li>• Public safety</li> </ul>	<ul style="list-style-type: none"> <li>• Academic governance and quality assurance</li> <li>• Program of study</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• The student experience</li> <li>• Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Public Safety</li> <li>• Academic governance and quality assurance</li> <li>• Program of study</li> <li>• The student experience</li> <li>• Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• Program of study</li> <li>• Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Public safety</li> <li>• Program of study</li> <li>• Assessment</li> </ul>	
Standards for assessment and accreditation of primary medical programs by the Australian Medical Council Date of effect: January 2013	<ul style="list-style-type: none"> <li>• The context of the medical program</li> <li>• Students</li> </ul>	<ul style="list-style-type: none"> <li>• The context of the medical program</li> <li>• The outcomes of the medical program</li> <li>• Learning and teaching</li> <li>• Assessment of student learning</li> <li>• Monitoring and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• The medical curriculum</li> <li>• Assessment of student learning</li> <li>• Monitoring and evaluation</li> <li>• Students</li> </ul>	<ul style="list-style-type: none"> <li>• The outcomes of the medical program</li> <li>• Assessment of student learning</li> </ul>	<ul style="list-style-type: none"> <li>• The context of the medical program</li> <li>• The Outcomes of the Medical Program</li> <li>• The medical curriculum</li> <li>• Learning and teaching</li> <li>• Assessment of student learning</li> <li>• Monitoring and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• The context of the medical program</li> <li>• Learning and Teaching</li> <li>• Assessment of student learning</li> <li>• The learning environment</li> </ul>	<ul style="list-style-type: none"> <li>• The context of the medical program</li> <li>• The outcomes of the medical program</li> <li>• The medical curriculum</li> <li>• Learning and teaching</li> <li>• The learning environment</li> </ul>	

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
Intern training – National standards for programs Published: January 2017	<ul style="list-style-type: none"> <li>The context in which intern training is delivered</li> <li>Organisational purpose</li> <li>Implementing the education and training framework – interns</li> </ul>	<ul style="list-style-type: none"> <li>The context in which intern training is delivered</li> <li>Monitoring and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>The context in which intern training is delivered</li> <li>The intern training program</li> <li>Assessment of learning</li> <li>Monitoring and evaluation</li> <li>Implementing the education and training framework – interns</li> <li>Delivering the training – supervision and educational resources</li> </ul>	<ul style="list-style-type: none"> <li>Assessment of learning</li> </ul>	<ul style="list-style-type: none"> <li>The context in which intern training is delivered</li> <li>The intern training program</li> <li>The training program – teaching and learning</li> <li>Assessment of learning</li> <li>Monitoring and evaluation</li> <li>Implementing the education and training framework – interns</li> </ul>	<ul style="list-style-type: none"> <li>The context in which intern training is delivered</li> <li>The training program – teaching and learning</li> <li>Assessment of learning</li> <li>Monitoring and evaluation</li> <li>Delivering the training – supervision and educational resources</li> </ul>	<ul style="list-style-type: none"> <li>The context in which intern training is delivered</li> <li>The intern training program</li> <li>The training program – teaching and learning</li> <li>Assessment of learning</li> <li>Delivering the training – supervision and educational resources</li> </ul>	
Standards for assessment and accreditation of specialist medical programs and professional development programs by the Australian Medical Council Date of effect: January 2016	<ul style="list-style-type: none"> <li>The context of training and education</li> <li>Trainees</li> </ul>	<ul style="list-style-type: none"> <li>The context of training and education</li> <li>The outcomes of specialist training and education</li> <li>Teaching and learning</li> <li>Assessment of learning</li> <li>Monitoring and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>The specialist medical training and education framework</li> <li>Assessment of learning</li> <li>Monitoring and evaluation</li> <li>Trainees</li> </ul>	<ul style="list-style-type: none"> <li>The context of training and education</li> <li>Teaching and learning</li> <li>Assessment of learning</li> </ul>	<ul style="list-style-type: none"> <li>The context of training and education</li> <li>The outcomes of specialist training and education</li> <li>The specialist medical training and education framework</li> <li>Teaching and learning</li> <li>Assessment of learning</li> <li>Monitoring and evaluation</li> <li>Trainees</li> <li>Implementing the program – delivery of education and accreditation of training sites</li> </ul>	<ul style="list-style-type: none"> <li>The context of training and education</li> <li>Monitoring and evaluation</li> <li>Implementing the program – delivery of education and accreditation of training sites</li> </ul>	<ul style="list-style-type: none"> <li>The context of training and education</li> <li>The specialist medical training and education framework</li> <li>Teaching and learning</li> <li>Assessment of learning</li> <li>Implementing the program – delivery of education and accreditation of training sites</li> </ul>	<ul style="list-style-type: none"> <li>Implementing the program – delivery of education and accreditation of training sites</li> <li>Continuing professional development, further training and remediation</li> <li>Assessment of specialist international medical graduates</li> </ul>
Accreditation standards: Medical radiation practice Published: December 2013	<ul style="list-style-type: none"> <li>Education provider and qualification registration</li> <li>Governance, management and resourcing</li> <li>Program attributes</li> <li>Qualification attributes</li> </ul>	<ul style="list-style-type: none"> <li>Governance, management and resourcing</li> <li>Education provider attributes</li> <li>Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>Governance, management and resourcing</li> <li>Program attributes</li> <li>Qualification attributes</li> </ul>	<ul style="list-style-type: none"> <li>Program attributes</li> <li>Professional capabilities of medical radiation practice program graduates</li> </ul>	<ul style="list-style-type: none"> <li>Education provider attributes</li> <li>Program attributes</li> <li>Professional capabilities of medical radiation practice program graduates</li> </ul>	<ul style="list-style-type: none"> <li>Governance, management and resourcing</li> <li>Program attributes</li> </ul>	<ul style="list-style-type: none"> <li>Governance, management and resourcing</li> <li>Program attributes</li> <li>Professional capabilities of Chinese medicine program graduates</li> </ul>	

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
Enrolled nurse accreditation standards Date published: 2017	<ul style="list-style-type: none"> <li>Governance</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Conceptual framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Students</li> <li>Resources</li> <li>Management of workplace experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Program development and structure</li> <li>Student assessment</li> <li>Students</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Program content</li> <li>Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>Conceptual framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Management of workplace experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Resources</li> <li>Management of workplace experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Resources</li> <li>Management of workplace experience</li> </ul>	
Registered nurse accreditation standards Date published: 2012	<ul style="list-style-type: none"> <li>Governance</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Curriculum conceptual framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Students</li> <li>Resources</li> <li>Management of Workplace experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Program development and structure</li> <li>Student assessment</li> <li>Students</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Program content</li> <li>Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>Curriculum conceptual framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Management of workplace experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Resources</li> <li>Management of workplace experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Resources</li> <li>Management of workplace experience</li> </ul>	
Nurse practitioner accreditation standards Date published: 2015	<ul style="list-style-type: none"> <li>Governance</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Curriculum framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Students</li> <li>Resources</li> <li>Management of integrated professional practice</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Program development and structure</li> <li>Student assessment</li> <li>Students</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Program content</li> <li>Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>Curriculum framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Management of integrated professional practice</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Resources</li> <li>Management of integrated professional practice</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Resources</li> <li>Management of integrated professional practice</li> </ul>	

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
Midwife accreditation standards Date published: 2014	<ul style="list-style-type: none"> <li>Governance</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Curriculum conceptual framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Students</li> <li>Resources</li> <li>Management of midwifery practice experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Program development and structure</li> <li>Student assessment</li> <li>Students</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Program content</li> <li>Student assessment</li> </ul>	<ul style="list-style-type: none"> <li>Curriculum conceptual framework</li> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Management of midwifery practice experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Resources</li> <li>Management of midwifery practice experience</li> <li>Quality improvement and risk management</li> </ul>	<ul style="list-style-type: none"> <li>Program development and structure</li> <li>Program content</li> <li>Student assessment</li> <li>Resources</li> <li>Management of midwifery practice experience</li> </ul>	
Accreditation standards for entry-level occupational therapy education programs Date of effect: December 2013	<ul style="list-style-type: none"> <li>Program overview, philosophy and purpose</li> <li>Practice education/fieldwork</li> <li>Resources</li> </ul>	<ul style="list-style-type: none"> <li>Program overview, philosophy and purpose</li> <li>Curriculum content and sequence</li> <li>Educational methods</li> <li>Educators</li> <li>Resources</li> <li>Continuing quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>Continuing quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>Educational methods</li> <li>Practice education/fieldwork</li> </ul>	<ul style="list-style-type: none"> <li>Program overview, philosophy and purpose</li> <li>Curriculum content and sequence</li> <li>Educational methods</li> <li>Practice education/fieldwork</li> <li>Local context of professional practice</li> <li>Educators</li> <li>Continuing quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>Practice education/fieldwork</li> <li>Local context of professional practice</li> <li>Educators</li> <li>Resources</li> </ul>	<ul style="list-style-type: none"> <li>Curriculum content and sequence</li> <li>Educational methods</li> <li>Practice education/fieldwork</li> <li>Continuing quality improvement</li> </ul>	
Accreditation standards and evidence guide for entry-level optometry programs (Part 2 – Standards) Date of effect: January 2017	<ul style="list-style-type: none"> <li>Public safety</li> </ul>	<ul style="list-style-type: none"> <li>Academic governance and quality assurance</li> <li>Program of study</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>The student experience</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Academic governance and quality assurance</li> <li>Program of study</li> <li>The student experience</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Program of study</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Program of study</li> <li>Assessment</li> </ul>	
Accreditation standards for osteopathic courses in Australia Published: July 2016	<ul style="list-style-type: none"> <li>Education provider registration and standing</li> <li>Resource allocation</li> </ul>	<ul style="list-style-type: none"> <li>Education provider registration and standing</li> <li>Program accreditation</li> <li>Resource allocation</li> <li>Assessment</li> <li>Scholarship and research in the curriculum</li> <li>Learning outcomes and curriculum content</li> </ul>	<ul style="list-style-type: none"> <li>Resource allocation</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Resource allocation</li> <li>Assessment</li> <li>Scholarship and research in the curriculum</li> <li>Learning outcomes and curriculum content</li> <li>Clinical content</li> </ul>	<ul style="list-style-type: none"> <li>Resource allocation</li> <li>Assessment</li> <li>Clinical content</li> </ul>	<ul style="list-style-type: none"> <li>Assessment</li> <li>Scholarship and research in the curriculum</li> <li>Clinical content</li> </ul>	

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
Accreditation standards for pharmacy programs in Australia and New Zealand Date of effect: January 2014	<ul style="list-style-type: none"> <li>Governance</li> <li>Strategic and operational planning</li> <li>Leadership and autonomy</li> <li>Financial resources</li> </ul>	<ul style="list-style-type: none"> <li>Governance</li> <li>Leadership and autonomy</li> <li>External relationships</li> <li>Infrastructure</li> <li>Human resources</li> <li>Curriculum development</li> <li>Curriculum management</li> <li>Experiential placements</li> <li>Student representation</li> <li>Quality management</li> <li>Risk management</li> </ul>	<ul style="list-style-type: none"> <li>Admissions policy</li> <li>Student selection</li> <li>Student support</li> <li>Student representation</li> </ul>	<ul style="list-style-type: none"> <li>Curriculum development</li> <li>Educational outcomes</li> </ul>	<ul style="list-style-type: none"> <li>External relationships</li> <li>Human resources</li> <li>Curriculum development</li> <li>Curriculum management</li> <li>Experiential placements</li> <li>Educational outcomes</li> <li>Student representation</li> <li>Quality management</li> </ul>	<ul style="list-style-type: none"> <li>Infrastructure</li> <li>Human resources</li> </ul>	<ul style="list-style-type: none"> <li>External relationships</li> <li>Experiential placements</li> <li>Educational outcomes</li> </ul>	
Accreditation standard for physiotherapy practitioner programs Published: December 2016	<ul style="list-style-type: none"> <li>Public safety</li> <li>Academic governance and quality assurance</li> <li>Program of study</li> </ul>	<ul style="list-style-type: none"> <li>Academic governance and quality assurance</li> <li>Program of Study</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>The student experience</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Academic governance and quality assurance</li> <li>Program of study</li> <li>The student experience</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Program of study</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Program of study</li> <li>Assessment</li> </ul>	
Accreditation standards for podiatry programs for Australia and New Zealand Published: May 2015	<ul style="list-style-type: none"> <li>Governance and program administration</li> <li>Policies and procedures</li> <li>Financial sustainability</li> </ul>	<ul style="list-style-type: none"> <li>Governance and program administration</li> <li>Strategic directions and autonomy</li> <li>Academic Leadership</li> <li>Student representation</li> <li>Curriculum philosophy and framework</li> <li>Learning outcomes and curriculum content</li> <li>Learning and teaching</li> <li>Research in the curriculum</li> <li>Quality monitoring mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>Student admissions and recognition of prior learning</li> <li>Student support and equity</li> <li>Student representation</li> </ul>	<ul style="list-style-type: none"> <li>Assessment of learning outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Strategic directions and autonomy</li> <li>Student representation</li> <li>Learning outcomes and curriculum content</li> <li>Clinical education</li> <li>Learning and teaching</li> <li>Quality monitoring mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>Clinical education</li> <li>Learning and teaching</li> <li>Assessment of learning outcomes</li> <li>Staff</li> <li>Facilities</li> <li>Patient care services</li> </ul>	<ul style="list-style-type: none"> <li>Clinical education</li> <li>Learning and teaching</li> <li>Assessment of learning outcomes</li> <li>Clinical training support</li> <li>Patient care services</li> </ul>	
Proposed accreditation standards for psychology programs Consultation: June 2016	<ul style="list-style-type: none"> <li>Public safety</li> </ul>	<ul style="list-style-type: none"> <li>Academic governance and quality assurance</li> <li>Program of study</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>The student experience</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Academic governance and quality assurance</li> <li>Program of study</li> <li>The student experience</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Program of study</li> <li>Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Public safety</li> <li>Program of study</li> <li>Assessment</li> </ul>	

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
OTHER STANDARDS								
Higher Education Standards Framework (Threshold Standards) 2015	<ul style="list-style-type: none"> <li>• Student participation and attainment</li> <li>• Governance and accountability</li> <li>• Representation, information and information management</li> </ul>	<ul style="list-style-type: none"> <li>• Teaching</li> <li>• Research and research training</li> <li>• Institutional quality assurance</li> <li>• Governance and accountability</li> </ul>	<ul style="list-style-type: none"> <li>• Student participation and attainment</li> <li>• Learning environment</li> <li>• Representation, information and information management</li> </ul>	<ul style="list-style-type: none"> <li>• Student participation and attainment</li> <li>• Teaching</li> </ul>	<ul style="list-style-type: none"> <li>• Student participation and attainment</li> <li>• Teaching</li> <li>• Institutional quality assurance</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Learning environment</li> <li>• Teaching</li> <li>• Research and research training</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Learning environment</li> <li>• Institutional quality assurance</li> </ul>	
Standards for Registered Training Organisations (RTOs) 2015	<ul style="list-style-type: none"> <li>• Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses</li> <li>• Standard 3. The RTO issues, maintains and accepts AQF certification documentation in accordance with these Standards and provides access to learner records.</li> <li>• Standard 4. Accurate and accessible information about an RTO, its services and performance is available to inform prospective and current learners and clients.</li> <li>• Standard 7. The RTO has effective governance and administration arrangements in place.</li> <li>• Standard 8. The RTO cooperates with the VET Regulator and is legally compliant at all times.</li> </ul>	<ul style="list-style-type: none"> <li>• Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses</li> <li>• Standard 2. The operations of the RTO are quality assured.</li> <li>• Standard 7. The RTO has effective governance and administration arrangements in place.</li> </ul>	<ul style="list-style-type: none"> <li>• Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses</li> <li>• Standard 3. The RTO issues, maintains and accepts AQF certification documentation in accordance with these Standards and provides access to learner records.</li> <li>• Standard 5. Each learner is properly informed and protected.</li> <li>• Standard 6. Complaints and appeals are recorded, acknowledged and dealt with fairly, efficiently and effectively.</li> </ul>	<ul style="list-style-type: none"> <li>• Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses</li> </ul>	<ul style="list-style-type: none"> <li>• Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses</li> </ul>	<ul style="list-style-type: none"> <li>• Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses</li> <li>• Standard 2. The operations of the RTO are quality assured.</li> </ul>		

Health profession accreditation standards	Corporate governance	Academic governance and quality assurance	Student experience	Student assessment	Program design and curriculum development	Learning resources (including staffing)	Clinical experience	In addition to common themes (if relevant)
<p>Draft National Safety and Quality Health Service Standards (version 2) Consultation: 2016 Anticipated release: 2017 Note: whilst it is recognised that these standards apply to health service organisations, the content and context is relevant to health professional programs of study.</p>					<ul style="list-style-type: none"> <li>• Clinical Governance</li> <li>• Partnering with consumers standard</li> <li>• Preventing and controlling healthcare-associated infection standard</li> <li>• Medication Safety Standard</li> <li>• Comprehensive Care Standard</li> <li>• Communicating for Safety Standard</li> <li>• Blood Management Standard</li> <li>Recognising and Responding to Acute Deterioration Standard</li> </ul>			



## Appendix 6: Examples of commonality and overlap between accreditation standards

ADC Accreditation Standards for Dental Practitioner Programs 2014	Roles/responsibilities – Dental Council (Accreditation Authority) (numbers refer to 'core evidence' required by ADC; <i>italics refer to examples of other types of evidence that could be submitted by education provider</i> )	Roles/responsibilities – academic boards	Roles/responsibilities – TEQSA
<b>1. Public Safety - Public safety is assured</b>			
1.1 Protection of the public and the care of patients are prominent amongst the guiding principles of the educational program, clinical training and student learning outcomes	Accreditation authority asks for: 1. Statement of guiding principles for the program <i>Other types of evidence</i> <ul style="list-style-type: none"> <li><i>Policies and procedures on student placement and supervision</i></li> </ul>		
1.2 Student impairment screening and management processes are effective	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li><i>Systems that identify, report on and remedy issues that may affect public safety and any actions taken</i></li> </ul>		
1.3 Students achieve the relevant competencies before providing patient care as part of the program	Accreditation authority asks for: 3. Curriculum mapping including alignment of learning outcomes to the relevant Professional Competencies	HESF 3.1 Course design	
1.4 Students are supervised by suitably qualified and registered dental and/or health practitioners during clinical education	Accreditation authority asks for: 5. Register of external supervisor's qualifications, registration status and supervision responsibilities 10. Staffing profile including professional qualifications, registration status and teaching and supervision responsibilities	HESF 3.2 Staffing	
1.5 Health services and dental practices providing clinical placements have robust quality and safety policies and processes and meet all relevant regulations and standards	Accreditation authority asks for: 2. Policies and procedures on clinical and workplace safety including screening and reporting and control of infectious diseases and blood borne infections 6. Policies and procedures on student placement and supervision 7. Register of formal (and informal) agreements between the provider and supervisors, placement clinics, practices and services	HESF 5.4 Delivery with other parties	
1.6 Patients consent to care by students	Accreditation authority asks for: 2. Policies and procedures on clinical and workplace safety including screening and reporting and control of infectious diseases and blood borne infections		
1.7 Where required, all students are registered with the relevant regulatory authority/ies	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li><i>Record of provider communication with ADC/DBA</i></li> <li><i>Student registration documentation</i></li> </ul>		
1.8 The education provider holds students and staff to high levels of ethical and professional conduct	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li><i>Policies and procedures on ethical and professional behaviour</i></li> </ul>		

ADC Accreditation Standards for Dental Practitioner Programs 2014	Roles/responsibilities – Dental Council (Accreditation Authority) (numbers refer to 'core evidence' required by ADC; <i>italics refer to examples of other types of evidence that could be submitted by education provider</i> )	Roles/responsibilities – academic boards	Roles/responsibilities – TEQSA
<b>2. Academic Governance and Quality Assurance - Academic governance and quality assurance processes are effective</b>			
2.1 The provider has robust academic governance arrangements in place for the program of study that includes systematic monitoring, review and improvement	<p>Accreditation authority asks for:</p> <p>8. Overview of formal academic governance arrangements for the program including program quality assurance, review and improvements.</p> <p><i>Other types of evidence</i></p> <ul style="list-style-type: none"> <li>● <i>Registration as a provider with appropriate authority e.g. TEQSA, ASQA, CUAP, NZQA</i></li> <li>● <i>Relevant academic policies and procedures</i></li> <li>● <i>Records, minutes of relevant review meetings and consultations and the decisions made and implemented</i></li> <li>● <i>Program/course approval documentation showing:</i> <ul style="list-style-type: none"> <li>○ <i>the consultation processes used and the level and nature of participation and advice by dental academics and professionals into the development and approval of the program and its components</i></li> <li>○ <i>Teaching staff</i></li> <li>○ <i>Curriculum content, including clinical placement hours</i></li> <li>○ <i>Learning environments, facilities and resources used, including clinical placements</i></li> <li>○ <i>Timetable</i></li> </ul> </li> </ul>	HESF 5.1 Course approval and Accreditation HESF 5.3 Monitoring, Review and Improvement	HESF 6.1 Corporate Governance HESF 6.2 Corporate Monitoring and Accountability HESF 6.3 Corporate Monitoring and Accountability
2.2 Quality improvement processes use student and other evaluations, internal and external academic and professional peer review to improve the program	<p><i>Other types of evidence</i></p> <ul style="list-style-type: none"> <li>● <i>Relevant key stakeholder consultation/engagement activities</i></li> <li>● <i>Records, minutes of relevant review meetings and consultations and the decisions made and implemented</i></li> <li>● <i>Samples of use of assessment data to improve program/course outcomes</i></li> </ul>	HESF 5.3 Monitoring, Review and improvement	HESF 6.3 Academic Governance
2.3 There is relevant external input to the design and management of the program, including from representatives of the dental professions	<p><i>Other types of evidence</i></p> <ul style="list-style-type: none"> <li>● <i>Relevant key stakeholder consultation/engagement activities</i></li> <li>● <i>Details of employer input/feedback</i></li> <li>● <i>Record of communication with ADC/DBA/DC(NZ) on relevant issues</i></li> </ul>	HESF 5.3 Monitoring, Review and Improvement	
2.4 Mechanisms exist for responding within the curriculum to contemporary developments in health professional education	<ul style="list-style-type: none"> <li>● <i>Relevant key stakeholder consultation/engagement activities</i></li> <li>● <i>Relevant external QA reports</i></li> </ul>	HESF 5.3 Monitoring, Review and Improvement	
<b>3. Program of Study - Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies.</b>			
3.1 A coherent educational philosophy informs the program of study design and delivery	<p><i>Other types of evidence</i></p> <ul style="list-style-type: none"> <li>● <i>Documentation showing where and how the educational philosophy is articulated and enacted</i></li> </ul>	HESF 3.1 Course design	
3.2 Program learning outcomes address all the relevant attributes and competencies	<p>Accreditation authority asks for:</p> <p>3. Curriculum mapping including alignment of learning outcomes to the relevant Professional Competencies</p>	HESF 1.4 Learning outcomes and assessment HESF 3.1 Course Design	

ADC Accreditation Standards for Dental Practitioner Programs 2014	Roles/responsibilities – Dental Council (Accreditation Authority) (numbers refer to 'core evidence' required by ADC; <i>italics refer to examples of other types of evidence that could be submitted by education provider</i> )	Roles/responsibilities – academic boards	Roles/responsibilities – TEQSA
3.3 The quality and quantity of clinical education is sufficient to produce a graduate competent to practice across a range of settings	Accreditation authority asks for: 9. Sample student timetable for each year of the course indicating allocation of key learning activities and clinical hours (indicating the number of hours spent as an operator) 13. Sample of student clinical log books/portfolios (which could be made available during the site visit)	HESF 1.4 Learning outcomes and assessment HESF 3.1 Course Design	
3.4 Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes	Accreditation authority asks for: 4. Assessment blueprint/matrix to demonstrate alignment of assessment to learning outcomes, including professional competencies	HESF 1.4 Learning outcomes and assessment HESF 3.1 Course Design	
3.5 Graduates are competent in research literacy for the level and type of the program		HESF 1.4 Learning Outcomes and Assessment HESF 3.1 Course design HESF 4.2 Research training	
3.6 Principles of inter-professional learning and practice are embedded in the curriculum	Accreditation authority asks for: 3. Curriculum mapping including alignment of learning outcomes to the relevant Professional Competencies		
3.7 Teaching staff are suitably qualified and experienced to deliver the units that they teach	Accreditation authority asks for: 5. Register of external supervisors' qualifications, registration status and supervision responsibilities 10. Staffing profile including professional qualifications, registration status and teaching and supervision responsibilities	HESF 3.2 Staffing	
3.8 Learning environments support the achievement of the required learning outcomes	Accreditation authority asks for: 7. Register of formal (and informal) agreements between the provider and supervisors, placement clinics, practices and services <i>Other types of evidence</i> • <i>Program/course approval documentation showing:</i> ○ <i>Learning environments, facilities and resources used, including clinical placements</i>	HESF 2.1 Facilities and Infrastructure	
3.9 Facilities and equipment are accessible, well-maintained, fit for purpose and support the achievement of learning outcomes	<i>Other types of evidence</i> • <i>Program/course approval documentation showing:</i> ○ <i>Learning environments, facilities and resources used, including clinical placements</i>	HESF 2.1 Facilities and Infrastructure, HESF 3.3 Learning Resources and Educational Support	
3.10 Cultural competence is integrated within the program and clearly articulated as required disciplinary learning outcomes: this includes Aboriginal, Torres Strait Islander and Māori cultures	Accreditation authority asks for: 3. Curriculum mapping including alignment of learning outcomes to the relevant Professional Competencies		

ADC Accreditation Standards for Dental Practitioner Programs 2014	Roles/responsibilities – Dental Council (Accreditation Authority) (numbers refer to 'core evidence' required by ADC; <i>italics refer to examples of other types of evidence that could be submitted by education provider</i> )	Roles/responsibilities – academic boards	Roles/responsibilities – TEQSA
3.11 The dental program has the resources to sustain the quality of education that is required to facilitate the achievement of the necessary attributes and competencies	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Letter from the provider senior management confirming ongoing support for the program</i></li> </ul>	HESF 3.3 Learning Resources and Educational support	HESF 6.2 Corporate Monitoring and Accountability
<b>4. The student experience - Students are provided with equitable and timely access to information and support.</b>			
4.1 Course information is clear and accessible	Accreditation authority asks for: 12. Information to prospective and enrolled students <i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>The program/course guides that are made available to students and detail how the program of study is structured and enacted at each stage</i></li> </ul>	HESF 7.2 information for prospective and current students	
4.2 Admission and progression requirements and processes are fair and transparent	Accreditation authority asks for: 11. Admission and progression policies and procedures <i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Sample of admission and progression decisions</i></li> </ul>	HESF 1.1 Admission	
4.3 Students have access to effective grievance and appeals processes	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Copies of relevant grievance and appeals procedures</i></li> <li>• <i>A register of grievances or appeals lodged, showing the outcome of the process</i></li> </ul>		HESF 2.4 Student Grievances and Complaints
4.4 The provider identifies and provides support to meet the academic learning needs of students	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Details of the academic and personal support services available to students</i></li> </ul>	HESF 1.3 Orientation and Progression	
4.5 Students are informed of and have access to personal support services provided by qualified personnel	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Details of the academic and personal support services available to students</i></li> </ul>	HESF 2.3 Wellbeing and Safety	
4.6 Students are represented within the deliberative and decision-making processes for the program	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Details of student representation within the governance and management of the program</i></li> </ul>	HESF 5.3 Monitoring, Review and Improvement	HESF 6.3 Academic Governance
4.7 Equity and diversity principles are observed and promoted in the student experience	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Policies and procedures on equity and diversity with examples of implementation and monitoring</i></li> </ul>	HESF 2.2 Diversity and Equity	

ADC Accreditation Standards for Dental Practitioner Programs 2014	Roles/responsibilities – Dental Council (Accreditation Authority) (numbers refer to ‘core evidence’ required by ADC; <i>italics refer to examples of other types of evidence that could be submitted by education provider</i> )	Roles/responsibilities – academic boards	Roles/responsibilities – TEQSA
<b>5. Assessment - Assessment is fair, valid and reliable</b>			
5.1 There is a clear relationship between learning outcomes and assessment strategies	Accreditation authority asks for: 4. Assessment blueprint/matrix to demonstrate alignment of assessment to learning outcomes, including Professional competencies  <i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Policies and procedures on assessment, including assessment strategy</i></li> <li>• <i>Samples of student assessments and feedback provided to students</i></li> </ul>	HESF 1.4 Learning outcomes and Assessment HESF 3.1 Course design	
5.2 Scope of assessment covers all learning outcomes relevant to attributes and competencies	Accreditation authority asks for: 4. Assessment blueprint/matrix to demonstrate alignment of assessment to learning outcomes, including Professional competencies  <i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Policies and procedures on assessment, including assessment strategy</i></li> <li>• <i>Samples of student assessments and feedback provided to students</i></li> </ul>	HESF 1.4 Learning outcomes and Assessment	
5.3 Multiple assessment tools, modes and sampling are used including direct observation in the clinical setting	Accreditation authority asks for: 4. Assessment blueprint/matrix to demonstrate alignment of assessment to learning outcomes, including Professional competencies  <i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Samples of student assessments and feedback provided to students</i></li> </ul>		
5.4 Program management and co-ordination, including moderation procedures ensure consistent and appropriate assessment and feedback to students	<i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Policies on and examples of assessment moderation</i></li> <li>• <i>Samples of student assessments and feedback provided to students</i></li> </ul>	HESF 1.3 Orientation and Progression	
5.5 Suitably qualified and experienced staff, including external experts for final year, assess students	Accreditation authority ask for: 5. Register of external supervisor’s qualifications, registration status and supervision responsibilities 10. Staffing profile including professional qualifications, registration status and teaching and supervision responsibilities  <i>Other types of evidence</i> <ul style="list-style-type: none"> <li>• <i>Processes for identifying and using external examiners</i></li> </ul>	HESF 3.2 Staffing	
5.6 All learning outcomes are mapped to the required attributes and competencies, and assessed	Accreditation authority asks for: 3. Curriculum mapping including alignment of learning outcomes to the relevant Professional Competencies	HESF 1.4 Learning outcomes and assessment, HESF 3.1 Course design	
36 elements			

## Appendix 7: The Accreditation Committee model from the Draft Report

As outlined in Chapter 6, the Draft Report proposed a model that aimed to separate the exercise of accreditation decisions under the National Law from the governance arrangements of external accreditation entities more generally. Specifically, it proposed removing reference to accreditation authorities and redefining accreditation committees under the National Law as being the responsible bodies for exercising the statutory functions.

Responses to this proposal were mixed, with the key concern being that this would impose an additional level of management and cost in the decision-making structures and that the proposed Accreditation Committees would not be reporting to existing accreditation councils. This was not an accurate representation, as it was envisaged that each Committee would report to its respective accreditation council in terms of its operations, but only that its individual accreditation decisions would be autonomous. The rationale for this is also outlined in Chapter 6.

The relevant section of the Draft Report is provided in this Appendix, with some elaboration based on stakeholder feedback and refinement of the Review's more general views on governance principles. It also includes description of the Health Education Accreditation Board (as named in the Draft Report) so as to explain the total governance arrangements and reporting relationships.

### Health Education Accreditation Board

1. The Health Education Accreditation Board would be responsible for:
  - Assignment of Accreditation Committees (see below).
  - Determination of national common cross-profession policies, guidelines and reporting requirements for inclusion in accreditation standards or for recommendation to National Boards for inclusion in professional competency standards.
  - Development and management of the overall relationships with TEQSA (and the academic boards of self-accrediting higher education institutions), ASQA and ACSQHC, including agreements with those regulators on policies and procedures for the clear delineation of responsibilities between the respective systems and how they interact.
  - Approval of accreditation standards developed in accordance with its policies and guidelines. The Health Education Accreditation Board would not have authority over the competency standards (which are an integral part of accreditation standards) developed by the National Boards or other profession specific requirements necessary within accreditation standards.
  - Determination of policies and guidelines on the criteria and processes for course accreditation and for assessment of international practitioners, following consultation with stakeholders such as education providers, National Boards, employers, professions, consumers and governments. This would include the development of common standards, fees and charges.
  - Determination of what elements of the NSQHS Standards should be incorporated into the accreditation standards and what elements should be recommended to National Boards for inclusion in professional competency standards.
2. The issuing of policy direction and any related approval of standards would be required to be output/outcome based. This means the policy and approvals would not be about how something was delivered but rather assessing that such matters had been addressed. This would further ensure that profession specific requirements can be addressed.

### Accreditation Committees

3. The Review considers that the management of defined accreditation functions under the National Scheme, and decisions made in relation to those functions, need to be by non-representational expertise that operates independently from representational structures, whether they be governing boards or other council arrangements. Further, if determinative responsibilities for accreditation functions are provided through new governance arrangements, those need to be subject to the same requirements for efficiency, transparency and review as other statutorily defined entities under the National Law.

4. It is important to provide a mechanism whereby the efficiency, transparency and review requirements are well defined and contained to the exercising of the accreditation functions. To remove all potential for future doubt and provide transparency, the decisions made that are part of any defined functions under the National Scheme need to be undertaken under arrangements that are clearly separate to:
  - the Health Education Accreditation Board outlined above
  - Boards and members of external accreditation entities more generally.
5. The Review considers the best way to achieve this is through redefining accreditation committees under the National Law. The National Law should be amended in a manner that defines the Accreditation Committee as a set of statutory functions rather than a statutory entity. Accreditation Committees, should have the following functions:
  - approval of programs of study and education providers and approval of any action required identified in the monitoring of programs of study and providers which meet approved accreditation standards
  - approval of authorities in other countries which conduct examinations for registration in a health profession, or accredit programs of study and approval of those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia
  - approval of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession, and advice of the assessment outcome to the relevant National Registration Board.
6. The three existing accreditation committees should become Accreditation Committees of the Health Education Accreditation Board, with administrative support continuing to be provided through AHPRA. Whilst they would be a committee of the Board, their decisions should be autonomous.
7. The Review is cognisant of the substantial contribution that has been made to accreditation by the current accreditation councils and the critical value they provide through expert professional input. Accordingly, the Review considers that the National Scheme should be agnostic to the governance structures of those councils. Accreditation Committees should be able to be appointed within an external entity (such as an existing accreditation council) provided that decisions that are made by Accreditation Committees under the legislated requirements of the National Law are so configured as to provide professional input to decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders (in particular, not be subject to approval by the Board of Directors of the external entity). A number of accreditation councils have similar arrangements already in place, with the exception that some decisions need to be signed off by governing boards of these councils.
8. The external entity must establish the Accreditation Committee's operations in a manner that would enable its functions to be covered in the same manner as other National Scheme entities defined in the Health Practitioner Regulation National Law Regulation and ensure that it would be autonomous in its decision making on approving or not approving of programs of study and providers on the basis of assessments. The alternative to this model would necessitate regulatory oversight of the broader external entity itself.
9. External entities should be permitted to have other commercial arrangements, provided their contracted accreditation functions are managed independently and transparently, including any conflicts of interest. None of the requirements for delivering the National Law accreditation decisions, however, should relate to the general governance and operations of any current accreditation council or other potential external accreditation entity, beyond normal contractual requirements.

## Roles and reporting relationships

10. The Health Education Accreditation Board, through AHPRA, would enter into an agreement with an external entity to deliver the functions of an Accreditation Committee. The Health Education Accreditation Board, beyond setting the transparency and public accountability requirements for the design of the Accreditation Committee, would have no involvement in the operations or decisions of either the external entity or of its Accreditation Committee.



11. The agreement would be executed and managed by AHPRA on behalf of the Health Education Accreditation Board. The agreement should include the transparency and public accountability requirements as well as performance measures and outputs and clear pathways for remedial action should any of the requirements or performance measures failing to be met.
12. The Health Education Accreditation Board should conduct regular reviews of the entities contracted to deliver the accreditation service and provide the opportunity for other bodies to tender for the function after the first five years of operation of the new arrangements.
13. A similar regime (non-contractual) should be put in place for the operation of the internal Accreditation Committees. Whilst they would be subject to a performance monitoring regime, their individual accreditation decisions should be autonomous.
14. Members of the Accreditation Committee:
  - Where it is a body established as a Committee of the Health Education Accreditation Board and supported by AHPRA, would be appointed by the Health Education Accreditation Board through a public EOI process.
  - Where it is located in an external entity, should be appointed by that external entity. The Health Education Accreditation Board would have no involvement in the selection of individual members.
15. Accreditation Committees would make decisions on the outcomes of the accreditation assessments only. The Accreditation Committee's responsibilities would be limited to the specified accreditation functions under the National Law. It would have no role in the overall management of accreditation operations. The external entity would be responsible for:
  - Management of, and support provided to, its Accreditation Committee
  - Formation and training of assessment teams and the conduct of on-shore accreditation assessments
  - Conducting assessments of overseas authorities and practitioners
  - Monitoring of performance, reporting on activity and decisions, etc. of the Accreditation Committee and reporting to governance body and AHPRA.
16. For the development of standards for approval by the Health Education Accreditation Board, in the case where the Accreditation Committee is in an external entity (such as an existing accreditation council), the overall responsibility would reside with the external entity with its Accreditation Committee playing a participatory role. In the case of internal Accreditation Committees, they would develop those standards for approval. It would be expected that the development of accreditation standards would have a broad consultation process and specific input from National Boards.

## Appendix 8: Review of specialist medical colleges' assessment of IMGs



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### External review of the performance of the specialist medical colleges performance in relation to the assessment of specialist international medical graduates

Deloitte Access Economics has been commissioned by the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Medical Board of Australia (the Medical Board) to review and report on the performance of the specialist medical colleges (the colleges) in relation to the assessment of specialist international medical graduates (IMGs). This review forms part of the Medical Board's and AHPRA's response to Recommendation 25 from the Independent Review of the National Registration and Accreditation Scheme for health professionals.

#### Scope of the review

The scope of the review is to explore the following lines of enquiry:

- 1) The extent to which each college's processes and procedures comply with the guidance in the *Good practice guidelines for the specialist international medical graduate assessment process (the Good practice guidelines)*;
- 2) The extent to which each college complies with specified compliance measures in the *Good practice guidelines*;
- 3) Each college's performance against the Medical Board's benchmarks for time measures relating to assessments;
- 4) Whether each college is applying standard assessment of specialist IMGs; and
- 5) Each college's assessment process for Australian and New Zealand medical graduates with overseas specialist qualifications.

The review will also consider:

- Whether the benchmarks and compliance measures set by the Medical Board are reasonable and an effective measure of college performance.
- Recommendations for the Medical Board's future monitoring of college performance.
- With reference to the advantages and disadvantages of the current model, we will recommend methods for optimising the way in which colleges assess specialist IMGs.

#### Out of scope

The review is limited to current college assessment of specialist IMGs. The following are out of scope of this review and should not be included:

- historical specialist IMG assessment processes pre 1 July 2014
- IMGs who have been accepted into the full accredited college training program
- training pathways for Australian and New Zealand graduates not seeking recognition of overseas specialist qualifications

- college specialist IMG processes that relate to a Medical Council of New Zealand component of the assessment
- college committees (or equivalent) other than those which have a role in specialist IMG assessments
- college governance structures other than where it relates to specialist IMG assessments
- college regulations, policies and procedures not directly related to specialist IMG assessments
- registration of specialist IMGs by the Board
- broader employment issues (other than issues relating to the requirements for supervised practice, workplace based assessments, etc.)
- immigration, visa and Medicare issues.

### **Fees**

Fees for the assessment process are being looked at in the context of whether the college process complies with the *Good practice guidelines*. The review will consider the fees set by the colleges for the assessment of

specialist IMGs in relation to the guidance in the *Good practice guidelines*, which state that the college can set fees, the fees are expected to be reasonable, they can set fees for specific stages of the assessment process and they must publish their fees. Analysis on the reasonableness of the fees will be based on feedback from the colleges, comparing the fees set across the colleges, and feedback from IMGs. Based on our findings, we may make recommendations in relation to the fees as part of our recommendations about optimising the assessment of specialist IMGs.

We will not be undertaking detailed financial analysis of the revenue generated by the colleges from the fees, the costs incurred by the college for the assessments and the net financial impact of the fees on the colleges operating budget. These aspects are outside the scope of what we were engaged to undertake.

### **National Specialist IMG Committee**

The National Specialist IMG Committee is a committee of the Board. The committee's terms of reference provide for them to make recommendations to the Board in relation to the assessment of Specialist IMGs. The committee does not have any decision making powers. The review will not comment on the terms of reference or performance of the National Specialist IMG Committee. The review may consider the role of the National Specialist IMG Committee in relation to the Medical Board's future monitoring of college performance in relation to the assessment of specialist IMGs and possible methods for optimising the way in which colleges assess specialist IMGs.

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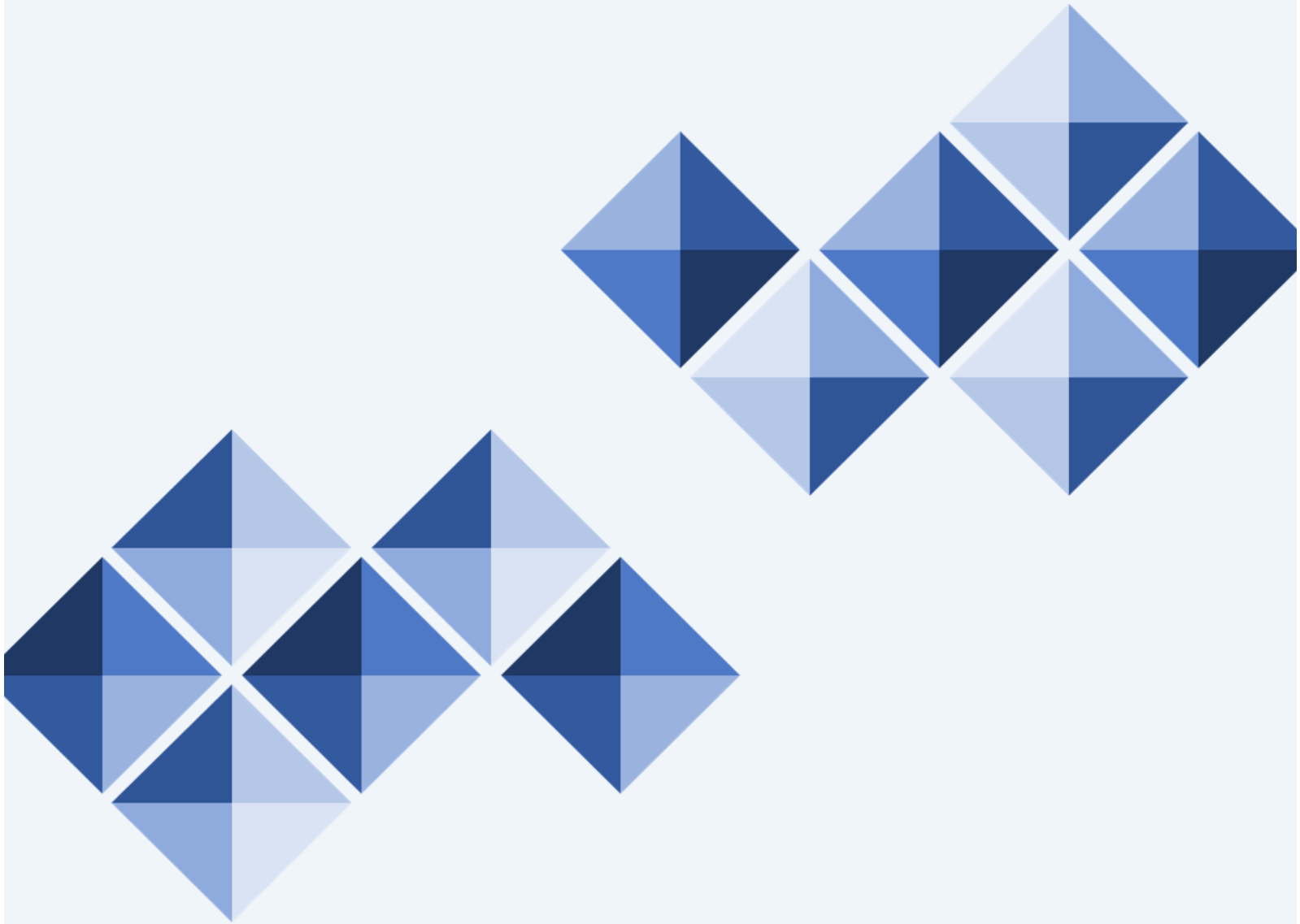


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