



AMC Submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions, May 2017

Introduction

The AMC is a national standards body for medical education and assessment. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. It has operated as an assessment and accreditation authority for the medical profession since 1985 – predating the National Registration and Accreditation Scheme by 25 years. Since the implementation of the Health Practitioner Regulation National Law in July 2010, it has been the designated accreditation authority for the medical profession.

The AMC supports the National Registration and Accreditation Scheme. Its organisational purpose links to the key objectives of the National Scheme.

The AMC's functions under its Constitution include:

- to improve health through advancing the quality and delivery of medical education and training associated with the provision of health services in Australia and New Zealand
- to act as an external accreditation entity for the purposes of the Health Practitioner Regulation National Law
- to develop accreditation standards, policies and procedures for medical programs of study based predominantly in Australia and New Zealand and for assessment of international medical graduates for registration in Australia
- to assess programs of study based predominantly in Australia and New Zealand leading to general or specialist registration of the graduates of those programs to practise medicine in Australia to determine whether the programs meet approved accreditation standards, and to make recommendations for improvement of those programs
- to assess education providers based predominantly in Australia and New Zealand that provide programs leading to registration of the graduates to practise medicine in Australia, to determine whether the providers meet approved accreditation standards
- to assess other countries' examining and accrediting authorities 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 medicine in Australia

- to assess or oversee the assessment of the knowledge, clinical skills and professional attributes of overseas qualified medical practitioners seeking registration to practise medicine in Australia
- to assess the case for recognition of medical specialties
- to advise and make recommendations to regulatory authorities and government
- to work with international health, accreditation and testing authorities and agencies to bring about improvement in the furtherance of these objects.

Rightly, the discussion paper asks questions about how accreditation works as a system within the National Scheme and the way in which the Scheme is governed to make an efficient, accountable accreditation system that meets the objectives of the National Law.

Most of the work of the AMC, as the accreditation authority for medicine, relates to medicine.

The AMC actively seeks national and international partnerships and review to build on strengths, develop and implement new activities, and continuously improve its performance as the accreditation authority for medicine. Our activities include: commissioning an international external review of the AMC in 2013, developing a more structured and visible commitment to Indigenous health and representation of Indigenous practitioners, students and community members across its accreditation and assessment functions; international review of accreditation functions; and staff exchanges and secondments with like bodies internationally. This approach provides Australia with internationally recognised and respected accreditation and assessment processes.

Business as usual operations as the accreditation authority for medicine include:

- assessment of international medical graduates: In the last financial year, the AMC examined a total of 2,421 candidates through its multiple choice examination and 1,997 candidates through an integrated 16-station clinical examination at 56 clinical examinations. Since the National Scheme began, the AMC has established the Vernon Marshal National Test Centre, a state of the art facility used to develop and deliver defensible high stakes clinical examinations (including most of the AMC clinical examinations).
- accreditation of programs of study: The AMC accredits a total of 126 primary and specialist medical programs offered by 37 education providers based in Australia and New Zealand. Sixteen of those providers offer medical programs of study only. The AMC also uses accreditation as a quality assurance tool for other medicine-specific processes: the state-based authorities that set standards for medical internship; Workplace Based Assessment programs for international medical graduates and Pre-employment Structured Clinical Interviews undertaken by international medical graduates. It sets standards for accreditation for these five processes, and reviews them on a five-yearly cycle.

The accreditation and assessment functions bring with them a number of related activities, which are not defined in the National Law, but which the AMC sees as integral to doing these functions well. They include:

- developing systems, for example the AMC qualifications portal which allows the uploading of material related to international medical graduate assessments between the AMC and the Medical Board of Australia and the specialist medical colleges and the Medical Board of Australia
- sponsoring the development of good practice, for example by providing the secretariat for the Association for Medical Education in the Western Pacific Region, contributing to the development of the World Federation for Medical Education's process for international recognition of accreditation authorities, sponsoring the World Directory of Medical Schools, and

developing a search tool linked to the Directory to enable IMGs to easily identify whether or not their school and qualifications are eligible for assessment by the AMC, or by specialist medical colleges, or for registration by the Medical Board of Australia

- contributing internationally to research on accreditation and assessment.

For the AMC, an established accreditation authority which operated national processes for accreditation of medical programs and assessment of international medical graduates before the National Law was implemented, certain fundamentals have not changed. These include the focus on protecting the public by ensuring that only medical practitioners who are suitably trained and qualified to practise in a competent and ethical manner are able to do so, on facilitating the rigorous and responsive assessment of overseas-trained medical practitioners, and on accreditation of programs to produce graduates to be safe and competent practitioners and to challenge education providers to respond to the healthcare needs of the community.

What has changed with the implementation of the National Scheme is:

- the increasing interprofessional collaboration between the accreditation authorities for the regulated professions. The AMC has demonstrated its commitment to engaging at this systems level and to interprofessional collaboration, by providing the secretariat for the Health Professions Accreditation Collaborative Forum since 2007, and by resourcing a number of interprofessional projects
- the source of authority for the AMC accreditation functions, the scope of some accreditation processes, the way in which some processes must be carried out to meet National Law requirements, and the reporting on AMC activities.

The AMC has used the opportunities created by the new Scheme to critically review processes and to develop new processes to enhance national standards of medical education, training and assessment. The transfer from the AMC to the Medical Board of Australia of the assessment competent authority applications by international medical graduates is an example of change made as a result of a process review and the development of a National Framework for Internship is an example of new standards development.

The National Scheme also necessitates interdependencies and cooperation between three groups that have accreditation-related roles and responsibilities: the Australian Health Practitioner Regulation Agency (AHPRA), the National Boards and the accreditation authorities.

AHPRA's roles in administering the Scheme are critical - development of guidelines, liaison between bodies, communication about requirements, managing data and systems, managing funding, and administration of registration and program approval processes. The AMC works with staff in the AHPRA national office on policy and national procedures, and the contractual relationship between the AMC and AHPRA for the performance of accreditation functions. It works with the AHPRA staff who support the Medical Board of Australia on a weekly basis. AMC staff work on a daily basis with staff of state and territory offices on matters to do with the status and qualifications of international medical graduates undertaking an AMC assessment.

The AMC has a strong relationship with the Medical Board of Australia and the staff who support the Board based on mutual respect for related roles in accreditation and standard setting, acknowledgement of expertise, and a shared commitment to meeting the objectives of the National Scheme. As the accreditation authority, the AMC sees that it has responsibility to ensure that the Medical Board has clear and accessible advice and information to complete its accreditation related roles, that the AMC manages risks and keeps the Board informed of important risks, and that we

work together to link quality of medical education and IMG assessment and quality of medical practice.

While the discussion paper acknowledges these three elements of the National Scheme, the focus seems to remain on the work, performance and accountability of the accreditation authorities. This approach will not address issues relating to cross profession collaboration and the effectiveness of the system as a whole; that requires accountability of the three contributing elements.

Accreditation is a relatively small component of a very large scheme. National Board funding contributions to accreditation amounted to 6% of the AHPRA budget in 2015/16. Yet as the discussion paper notes, accreditation in the context of the National Law context is antecedent to, and inextricably bound together with, practitioner registration. The AMC does not see any particular barrier to it continuing to perform its accreditation functions and to improve processes while ever it has sufficient funding for the work and continues to have excellent relationships with the Medical Board of Australia. However, the discussion paper identifies some challenges that need to be addressed and resourced at a systems-level rather than between an individual accreditation authority and the relevant National Board. There is not a clear mechanism to bring together all parties to set performance expectation or goals for this element of the National Scheme. Proposals to address these challenges are addressed in the governance section of this response. These proposals align with those submitted by the Health Professions Accreditation Collaborative Forum.

The Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions is encouraging accreditation authorities, National Boards and AHPRA to consider a wider definition of efficiency, taking into account the costs of compliance for education providers and areas of duplication, and to re-consider the relevance and responsiveness of accreditation to meeting the health needs of the Australian community. The AMC appreciates the opportunity to contribute to the Review, and looks forward to working with the Review to define and implement improvements in the efficiency and effectiveness of accreditation within NRAS.

Improving Efficiency

The AMC agrees that an efficient accreditation system requires sound and fit for purpose processes.

Effective accreditation processes:

- are based on peer review, which ensures that the assessment is informed by expertise appropriate to professional education programs. The success of these processes is due to the willingness of individual medical practitioners, academics and educationalists to give their time and expertise to support these activities in the interests of the professional standards. This enables the AMC to undertake tasks such as reviewing standards, developing policy, establishing teams with the expertise appropriate for a specific assessment at a high standard and less than full cost. Review by peers is also more able to bestow or withdraw esteem on those reviewed, and thereby motivate continuing self-improvement¹.
- 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

¹ McCormick B Pathway Peer Review to Improve Quality The Health Foundation November 2012 <https://www.england.nhs.uk/wp-content/uploads/2013/11/NQB-12-05-01-a.pdf>

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)

- are collaborative and collegial, and recognise and learn from the expertise in the education providers undergoing accreditation. This is characterised by the Association of Specialized and Professional Accreditors as “Works with issues of autonomy in light of the commitment to mutual accountability implied by participation in accreditation activities, while at the same time, respecting the diversity of effective approaches to common goals, issues, challenges, and opportunities exhibited by accrediting bodies, institutions, and programs.”²

These elements shape the accreditation processes and to some extent their cost and efficiency.

Accreditation processes across the professions have common elements, but there are variations in emphasis and how they are applied. Variations include length of accreditation cycles, terminology, how and what data are gathered to assess whether standards are being met, wording of accreditation decisions, size of teams, and size, length and use of site visits. The AMC agrees that some of this variation is based on custom and practice. It is very willing to explore commonality in terminology and approaches, through the Health Professions Accreditation Collaborative Forum. Nevertheless, what is fit for purpose depends in part on the nature of the education providers, the programs of study and discipline.

For example, most specialist medical colleges span Australia and New Zealand. The training model includes more practical, workplace based training and assessment than it does formal education programs, and the trainees are registered medical practitioners, delivering services while they train. The providers are not registered higher education providers and are not subject to other regulated accreditation processes. Two examples of variation - elements of the AMC process for assessment of specialist medical programs that are not used in other accreditation processes are:

- The AMC invites submissions on the program being reviewed for accreditation, including a survey of trainees and supervisors of training, and seeking submissions from health departments. These processes are time consuming but add important stakeholder feedback to the AMC’s assessment of the program
- The team attends the annual scientific meeting of the College/specialty. This provides a very valuable opportunity for the team to learn about developments in the science and practice of the specialty, as well as an opportunity to meet discipline leaders, training supervisors and trainees.

The discussion paper indicates “The NRAS accreditation process costs over \$40M per annum.” This figure includes all processes that are defined as accreditation functions, not just the accreditation of programs of study. The AMC accreditation of programs of study costs \$3.5 million. Its assessment of international medical graduates costs \$13.7 million.

Accreditation Standards

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

² http://www.aspa-usa.org/wp-content/uploads/2015/02/recognition_position_2011.pdf

Consistency in the *process* for development of accreditation standards flows from AHPRA's Procedures for Development of Accreditation Standards. This document set out the principles and steps to be followed in development of standards. These include legislative and consultative considerations, as well as relevant international standards and COAG principles for best practice regulation. Following these principles leads to considerable consistency in the development of accreditation standards across professions, with the benefits of stakeholder buy-in, professional acceptance, and alignment with good practice internationally. In addition, the requirement concerning consultation with the Office of Best Practice Regulation requires accreditation authorities to consider the impact of changes to standards and how those impacts will be addressed.

The NRAS Accreditation Liaison Group measured accreditation costs across all fourteen NRAS professions in 2016. This exercise found that the cost of development of standards according to these principles was A\$1.3M in 2015/16 across all NRAS professions³ (with unquantified but minor costs for entities consulted in the course of standards development). There may be potential for savings through further process standardisation, or perhaps tailoring consultation levels to the magnitude of proposed standard changes, however given the small amount of resources involved it does not seem large savings will flow from such activities.

The AMC's responsibility to review and develop appropriate accreditation standards requires it to engage in robust and open debate with stakeholders about the standards and the rationale for changes to them. This should lead to standards being well accepted and well understood, and at the right level. This is a time consuming process, if it is done well. There will always be differences in the extent of consultation required on standards development across professions. The AMC conducted three main consultation phases when it revised the Standards for Assessment and Accreditation of Specialist Medical Programs and Continuing Professional Development Programs: on the initial scope of the review, on the first draft of the revised standards, and on the second draft of the revised standards. It consulted 80 stakeholders. Stakeholder feedback from consultations also may necessitate additional consultation and changes in the development of specific standards.

Under the National Law, each accreditation authority develops accreditation standards for a specific profession, and the reference documents for that accreditation authority will depend in part on the profession. The AMC develops accreditation standards for programs in all stages of medical education and training. It aims to: keep standards common across these stages (while recognising differences in training settings, teaching and learning methods, and the status of trainees/students), keep them in line with international peers (so that it can retain international recognition) which bring benefits to medical schools in terms of international student recruitment, and ensure consistency with other national standards.

There is significant interaction across accreditation authorities when they develop accreditation standards, each learning from the experience of the other, leading to a level of commonality in accreditation standards. Accreditation authorities draw on phrases, structures and elements of each other's standards or guidance to standards where these are seen as good practice. Standards developed by the Australian Dental Council have been proposed for adoption by at least four other accreditation authorities. Elements of AMC standards and guidance are included in others' notes and guidance. We see this as part of the collegial sharing that occurs.

³ <http://www.ahpra.gov.au/News/2017-03-03-new-accreditation-publications.aspx>

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.

The implementation of the accreditation standards of the Australian Dental Council across five professions provides an opportunity to evaluate the effectiveness of those standards in different professions, and the longer term impact of commonality in standards. For example, will it streamline the work of education providers undergoing accreditation? If so how? And to what extent?

A potential barrier to greater commonality is the way the National Scheme is structured, with each accreditation authority reporting to one National Board. While there was collaborative work by five accreditation authorities to decide to use one set of standards, the structure of the Scheme means that each accreditation authority has consulted separately and managed approval of the standards through AHPRA and their National Board processes.

The AMC applies standards to assess medical programs for the purposes of accreditation. Under the *National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes. The AMC also applies the accreditation standards in monitoring that accredited programs and providers continue to meet the standards.

There may be greater potential for efficiencies to be gained in this *application* of standards (that is accreditation processes) than in their development. This set of activities cost A\$11M in 2015/16 across all NRAS professions⁴, with additional unquantified costs borne by accredited entities. The AMC's response to this question is covered under question 4.

With regard to the overall efficiency of accreditation operations, the AMC has undertaken benchmarking with some international counterparts. Our findings are as follows:

- 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.
- The AMC's other main cost area is international medical graduate assessment. Current registration fees to take the USMLE exams is A\$5990 per IMG. This is about 5% less than the fees for IMG testing in Australia, and the US benefits from considerably larger scale. The AMC has made significant investments in the development of rigorous, defensible and transparent assessment processes, including the development of the National Test Centre in Melbourne, new processes for developing the content and marking of clinical testing, examiner and standardised patient training.

⁴ <http://www.ahpra.gov.au/News/2017-03-03-new-accreditation-publications.aspx>

Using the ALG costings data, the Forum found that, across the NRAS professions, per registrant costs were driven mainly by scale and the number of accredited programs for each profession. The larger the profession, the lower was the cost per registrant. The more programs accredited, the higher was the cost per registrant. Together these two factors explained 75% of variation in the cost per registrant across professions⁵. In other words, accreditation costs were driven by the expected factors of high fixed costs and the amount of work to be done. There did not appear to be a substantial element of arbitrariness that might arise from authorities abusing their powers.

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

The AMC has an MOU with TEQSA to share information. The purpose of the MOU is partly to ensure a coordinated approach to accreditation rather than duplication. TEQSA decisions relate to institutions (and their registration as providers) not to medical programs per se, since primary medical programs are all offered in self-accrediting higher education providers. While at an early stage, the information sharing between the AMC and TEQSA is growing and has potential to streamline some data collection.

The AMC and other health profession accreditation authorities have mapped their standards to the Higher Education Standards. Mapping helps to ensure that the wording of standards applied to the accreditation of health professions programs is not inconsistent with that of the Higher Education Standards. The existence of a strong national system for regulation of higher education providers means that the AMC does not need to assess the stability and capability of the higher education provider, or its academic governance or staffing processes. When compared to other medical program accreditation authorities, the AMC's processes are light in these areas⁶. The AMC is not asking education providers to report on university structures and processes in general, but on the resources, structures and processes that support the delivery of the medical program. Frequently, there is a combination of university structures, processes and resources as well as health or discipline-specific ones, and so the AMC may require information on both levels.

TEQSA exists and operates under legislation with different aims and requirements to those of the Health Practitioner Regulation National Law. TEQSA states that its main aim is upholding standards for students, whereas the aim of accreditation under the National Scheme is public protection.

There are differences in the definition of an education provider so that the organisations regulated by TEQSA and accredited under the National Law are not the same. The TEQSA Act definition of a higher education provider links to the provider conferring a regulated higher education award. The definition of an education provider under the Health Practitioner Regulation National Law is broader: it includes a university; or (b) a tertiary education institution, or another institution or organisation, that provides vocational training; or (c) a specialist medical college or other health profession college. These differences are significant – not all education providers under the National Law are seeking the status of registered higher education provider with TEQSA or offering a higher education award.

⁵ Multiple regression using log-log transformation of variables. Certain data points removed as outliers.

⁶ The AMC is drawing specifically on its experience in comparing its standards to those of the US Liaison Committee for Medical Education

Conditions on accreditation are also defined differently in the legislation, as are the penalties or responses required to when standards or conditions are not met. These differences are significant.

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

While the AMC does not use an overt risk-based approach, the assessment of risk that providers and programs will not meet standards is a critical element in any accreditation decision. This assessment leads to decisions about the length of period of accreditation granted to a program, the conditions placed on the accreditation, and the forms and degree of monitoring of the program.

The AMC accreditation cycle for education programs is 10 years (the longest cycle of any of the accreditation authorities). This cycle is designed as a maximum period of six years accreditation after an assessment visit, followed by the potential to extend the accreditation by a further four years, based on the education provider submitting a comprehensive report that demonstrates that the provider is continuing to meet standards, and will meet standards for the proposed extended period.

The AMC's experience in the accreditation of medical schools is that most programs require reaccreditation before their ten year cycle finishes, based on the pace of major change in accredited medical programs. The AMC developed early a definition of a major change as a way of identifying the sorts of changes that increase the risk that an accredited program may no longer meet the accreditation standards. The AMC reviews this definition regularly, taking account of its accreditation experience. The AMC sees some benefits in reframing its policy on major changes to programs in "risk based accreditation" terms and will begin work on this in 2017.

It is worth noting that agencies with well-developed approaches to risk assessment frequently combine an annual assessment of risk (and gathering of data to support that assessment) with periodic deeper assessments or reaccreditations.

TEQSA, for example, indicates that its risk assessments provide a snapshot of providers across the sector to help prioritise TEQSA's focus in undertaking its assurance activities but that its risk assessments do not draw conclusions about compliance with the Threshold Standards....TEQSA's assessment processes, such as a renewal of registration, involve a deeper assessment of evidence to determine compliance with the Standards.^{7 8}

To meet international standards for recognition, the AMC needs to have a cyclical process which requires a more in-depth review at the end of the cycle. The World Federation for Medical Education process for recognition of accreditation agencies⁹ indicate that the accreditation agency must conduct a site visit or visits to a medical school before making an accreditation decision and that it must require medical schools to be re-evaluated periodically after a positive accreditation decision. Similar requirements exist in the criteria for the National Committee on Foreign Medical Education

⁷ TEQSA's Risk Assessment Framework version 2.1. February 2016
http://www.teqsa.gov.au/sites/default/files/TEQSA_Risk_Assessment_Framework_v2.1_2.pdf

⁸ See also the Accreditation Council for Graduate Medical Education in Nasca T J., Philibert, I., Brigham, T., Flynn, T C. *The Next GME Accreditation System — Rationale and Benefits* N Engl J Med 10.1056/nejmsr1200117

⁹ <http://wfme.org/accreditation/accrediting-accreditors/recognition-process>

Accreditation¹⁰. The AMC undergoes regular review by this US Department of Education committee. A determination of comparability of AMC accreditation standards and processes to those used by the Liaison Committee for Medical Education is an eligibility requirement for foreign medical schools to participate in the William D Ford Federal Direct Student Loan Program. Australian medical schools benefit directly from this determination in recruitment of medical students (more than 500 students are currently studying in Australian programs and accessing these loans).

In this as in other areas, the AMC is open to further modifications to the system, subject to the development of appropriate risk indicators (and there is discussion between the accreditation councils on this). We are currently examining the utility of various additional and alternate data sources and reporting formats to see whether they support further moves in the direction of risk managed approaches to accreditation. The planned implementation of a National Training Survey in Australia, similar to the General Medical Council's National Training Survey, will improve the data about the quality of training and enable changes in the AMC accreditation of specialist medical programs, including better identification of risks.

ANMAC's introduction of a risk-based regime will also provide an opportunity to assess how well such a regime delivers in the accreditation context.

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and inter-professional collaboration?

The question is a broad one: what changes could be made to processes to increase efficiency and interprofessional collaboration, although the example, the work of the teams, is narrower.

The AMC is planning to reap process improvements in accreditation from investing in information technology - replacing its accreditation management system, a bespoke project management system, with an application developed by a vendor specialising in accreditation systems. The features of the new web-based software should streamline tasks for the AMC and education providers through increased document and process automation and workflow management, aiming to create internal and external efficiencies and enhance consistency across processes. Future developments in this system include "registry" functions, which will allow accreditation decisions and information of other accreditation authorities to be captured and shared. The system will also allow the AMC to review the efficacy of standards by allowing more timely analysis of which standards lead to accreditation conditions or commendations, and of changes in findings against standards over time.

Interprofessional collaboration occurs through the Forum, as documented in the Forum's submission to the review, although capacity for collaboration is limited by resource constraints. It also occurs through direct relationships between accreditation councils. The AMC has used members of other professions' accreditation processes on its teams, and involved them in its team training processes. Since March 2017, the AMC, the Australian Nursing and Midwifery Council (which supports the Australasian Osteopathic Accreditation Council) and the Australian Pharmacy Council have been collocated in the one precinct, and are building on their physical proximity to establish interest groups to address common issues and share knowledge. The AMC and the Australian Dental Council

¹⁰ <https://sites.ed.gov/ncfmea/files/ncfmea-dir/2013-mtg/ncfmea-guidelines-10-2013.pdf>

have a long history of collaboration in accreditation and assessment of overseas trained practitioners, predating the Scheme. The AMC the ADC have a joint accreditation process to review programs in oral and maxillofacial surgery which is both a dental and a medical specialty. Although the AMC and ADC have different standards and processes, the two Councils are able to map their standards to produce one common accreditation report, and to combine processes to support a sensible joint accreditation.

The AMC agrees with the Review that process standardisation should be explored in order to reduce process costs. However, national and international experience in standardising terminology and processes, suggests that the unintended consequences of this can be the stifling innovation, and applying processes that do not fit the specific requirements of any individual profession.¹¹

We agree with the Review that there is benefit in professions' accreditation authorities working together to ensure consistent quality in training and other aspects of team management.

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.

Accreditation assessment teams are however only one element of the accreditation processes. The findings from teams are moderated through:

- The work of the team as a whole, including accreditation staff. While one reviewer may have a particular interest, most accreditation authorities provide guidance to their staff (if staff accompany the team) and to team members in general on how to respond should any one member extend the scope of the accreditation assessment or behave unprofessionally.
- For most accreditation authorities, the accreditation teams do not make the accreditation decision. They provide a report on findings, and the education provider has an opportunity to comment on that report. Usually there is an accreditation committee that reviews reports for sense, consistency, and balance. This process allows team findings to be tested and reviewed, and for the provider to seek reconsideration if necessary.

The AMC has also developed templates and processes to ensure that each team assesses the program against the accreditation standards and that committees monitor programs against the standards. Its processes have been adopted for medical school accreditation processes in a number of other countries in the Western Pacific region, including the Republic of Korea and the People's Republic of China.

¹¹ See for example the US Council for Higher Education Accreditation *Position Paper Regulatory Relief for Accreditation* April 2017 <http://www.chea.org/userfiles/Occasional%20Papers/Regulatory-Relief.pdf>

There is also an important role for accreditation staff in ensuring that processes are applied consistently and efficiently. AMC staff contribute to shaping accreditation recommendations, preparing reports, evaluation of processes, and analysis of accreditation-related data teams. They develop procedural guides to guide each team and to ensure they focus on the standards. The Forum has facilitated collaboration between staff of different accreditation authorities through workshops and the Accreditation Managers Subcommittee.

The Forum has surveyed remuneration practices and found some parity in these practices across professions. While remaining differences in remuneration should be able to be removed, this may add to the costs of providers, and would need to be discussed. It would facilitate initiatives such as pooling of potential team members in some areas.

Remuneration for team members does not fully compensate for lost income. Our team members are motivated by their interest in accreditation, their concern for standards of medical education, and the opportunity to participate in a well-accepted peer review system. The distinctive character of teams and individual contribution of team members must continue to be recognised if the peer review model is to deliver its full potential.

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

The AMC adopted a broad definition of “peer review” in 2000. AMC teams include a broad range of expertise and viewpoints. They may include: health consumers, healthcare administrators, students/trainees, educationalists, and academics (both medical and non-medical). However teams are not stakeholder representative groups. They are selected first and foremost for skill and expertise appropriate for the scope of the accreditation assessment. There is a dialogue with the education provider about the specific expertise that will be useful on the team. When assembling teams the AMC aims to balance skills and expertise required for the specific assessment with issues such as cost and benefits of diversity, to ensure continuity and consistent quality of assessment.

In the AMC’s experience, there is value in teams having multiple view points and a variety of expertise but the benefits of adding additional members to teams must be balanced with team costs. Expanding teams may also add to additional training costs. For example, when the AMC first introduced health consumer members on its committees and teams it ran regular training workshops for this group, and produced separate guides and reference material for them.

As noted above, accreditation teams are not the only elements of the accreditation process. A broad range of stakeholders also sit on AMC accreditation committees, and as members of the Australian Medical Council.

Sources of accreditation authority income

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

The key principle should be that funding of accreditation functions is 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.

The discussion paper lists the beneficiaries of the accreditation system, including education providers, students, registered practitioners and health consumers. Governments are also a beneficiary of the accreditation system, as the National Scheme is intended to meet public good

objectives. All users should contribute to the Scheme, that is, registrants, education providers, and, recognising the public benefit of safe and competent health practitioners, public funding.

The AMC sets charges on a basis that allows cost recovery for an accreditation assessment of a program (including an accreditation visit if necessary) and monitoring of the program as required under the National Law. The charges do not cover the additional costs of managing the AMC accreditation processes such as team training, pre-visit preparation, staff support, committee meetings and so on. The Medical Board of Australia (via AHPRA) has fully funded those costs for the last two financial years.

The setting of charges is based partly on a user-pays principle. In a monitoring regime, where some institutions may have higher demands for accreditation services, (whether, for instance, by triggering risk parameters or establishing new programs of study), it is more equitable and efficient for institutions requiring additional assessments to pay additional costs. It also creates an expectation that teams will provide a valuable service, and our teams are cognisant of the service they are providing to medical education and training.

The current process do not provide transparency in relation to funding

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

The AMC is a standard setting body for the medical profession. The graduate outcome statements and intern outcome statements apply not only to domestic graduates but also to international medical graduates. The two streams of work, accreditation and IMG assessment, are intertwined. They use the AMC's administrative and business approaches, IT and other resources, and build on the same knowledge base and the input of large group of experts – many contribute across both streams.

The AMC does not currently cross-subsidise program accreditation functions with income derived from assessment of overseas qualified practitioners. This cost independence includes allocation of indirect costs and overheads, and is calculated on an annual basis. The AMC's IMG assessment processes are self-funding. They do not require funding from the Scheme.

AHPRA funds the costs of program accreditation not covered by accreditation income from education institutions. AHPRA also funds the AMC work in the setting of standards for intern training.

Relevance and responsiveness

The AMC strongly supports the emphasis in the National Law objectives on quality improvement of education - facilitating the provision of high quality education and training of health practitioners and enabling innovation in the education of health practitioners.

Internationally, medical program accreditation processes foster quality improvement by beginning the process with the education provider undertaking a critical self-assessment of its strengths, weaknesses and challenges. These self-assessment processes are followed by peer review and assessment, with the aim of building on the provider's own assessment.

Medical education, medical knowledge and medical practice are dynamic, and evolve rapidly. The accreditation standards and process must be set at a sufficiently high level to allow evolution and innovation linked to evaluation of changes proposed and made.

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

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.

Accreditation of a program of study applies over a period of time. The decision is based not just on the program and provider meeting the standards at a point in time but also into the future, this is consistent with the objectives of the National Law relating to the continuous development of a flexible, responsive and sustainable Australian health workforce and innovation in the education of health practitioners. Standards relating to stability, capacity, and program evaluation are important in this assessment. For primary medical programs, TEQSA registration of the higher education provider addresses measures of organisational capacity, although not all providers are subject to TEQSA processes.

Process standards can also address efficiency in education processes. In the early phase of AMC accreditation of specialist medical programs, the AMC commonly found that graduates of specialist medical programs were of high quality but that potentially good doctors did not graduate or their completion took longer than optimal. Process standards have contributed to colleges addressing these requirements. Relevant standards include requirements for a clear curriculum framework, program structure, linking of curriculum to assessment, trainee evaluation and feedback to improve programs, trainee support, and clear communication and information.

Other medical program accreditation process standards address topics such as engagement of health consumers, health services, and indigenous groups in curriculum review and evaluation. The AMC has also recently strengthened process standards concerning a safe and effective learning environment and trainee wellbeing, and addressing bullying and harassment. There is international evidence that doctors' learning and practice is influenced by the training environment including workplace culture.^{12 13}

There are also specific circumstances where outcome based standards are not applicable, for example a new program or major changes to an accreditation program.

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

The AMC does not see that changes are required in assessment processes for medicine. The AMC accreditation is focussed on outcome based standards, supplemented by appropriate input and process standards, and assessment processes designed to assess performance against those standards.

¹² The General Medical Council The state of medical education and practice in the UK: 2015 reports that in a survey of trainees, there was 12% greater likelihood of trainees reporting a serious medical error if they worked in organisations where reporting was encouraged, than for trainees working in organisations where staff were reluctant to report errors. <http://www.gmc-uk.org/publications/somep2015.asp>

¹³ Australian Medical Association Workplace Bullying and harassment 2015 <https://ama.com.au/position-statement/workplace-bullying-and-harassment>

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

The development and maintenance of competency frameworks is a core activity of NRAS accreditation. 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.

The AMC regards the graduate outcome statements as a key part of the accreditation standards, not as a separate document. For this reason, we consult widely on them when we consult on development of or changes to accreditation standards. 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.

The AMC is aware that this is not the case for all professions. For some professions these frameworks are developed by the profession or the National Board. If developed by a National Board, then the usual AHPRA consultation procedure should apply. These procedures indicate that other National Boards and accreditation authorities should be consulted, although they don't specify other professions be consulted.

While competency frameworks themselves are profession-specific, the AMC considers that there would be benefit in greater harmonisation in the process for developing them. Since the AMC's graduate outcome statements are embedded in our accreditation standards they undergo the process for review in AHPRA's Procedures for Development of Accreditation Standards. The key principles and steps in AHPRA procedures, which require wide ranging consultation as well as regard to the objectives of the National Law, might serve as the basis for principles for development of competency frameworks.

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

There are clearly some elements of health profession curriculum content that are common and a common foundational knowledge would be of benefit, for example Indigenous health. The AMC is interested in researching further which standard areas could be harmonised, but supports an evolutionary approach, given the importance of getting it right. The AMC can work with others through the Forum to build work on shared accreditation standards or principles to assess the viability of common health profession elements/domains. This has been the case in developing shared principles on interprofessional learning and on work the Forum is taking forward on standards to achieve a common understanding of the safe use of medicines across professions, irrespective of the profession's role in prescribing.

The AMC believes some caution is warranted when considering commonality in standards themselves, rather than commonality in their development or application.

Too strong a focus on commonality may stifle innovation in a specific profession. Issues may arise in one profession before they arise in other professions. For example, the AMC's development of

standards concerning student professionalism and fitness to practice were promoted by specific discussions with stakeholders, including members of the Australian Medical Council. While these standards may be of value for other professions they may not be regarded as so urgent.

The experience of standards harmonisation is that it can lead to standards being set at a higher level to ensure greater applicability i.e. the standards become more generic and less profession specific.

There are costs in any changes in accreditation standards and redesign of standards on a core plus profession-specific model would entail significant change. Accreditation authorities would have significant work to develop new standards; writing them and consulting across the professions and stakeholder bodies, as well as work in transitioning to new standards through the development of new accreditation guides and templates, and team and committee training. The work for education providers in reporting against new standards is not insubstantial. It entails setting up mechanisms to capture data for accreditation reporting purposes and in some cases developing new policies and oversight groups where new standards introduce new requirements.

There are potential hidden costs from creating one-size-fits-all standards. There will be higher costs of and greater time required for consultation and review on standards across 14 professions. The standards may not be as responsive to changes in education and the health care environment, with the consequences that accreditation becomes more compliance-focused and less capable of generating initiatives for improvement.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

The question has a number of elements:

- How accreditation processes influence the evolution of programs to take account of changes in medical and scientific knowledge and medical practice, as well as the structure of the health care system. Programs are continuously evolving and accreditation standards and processes can be structured to facilitate this change. There is no barrier to a medical program adapting by for example, expanding the curriculum content in an area or increasing the amount of clinical experience in a discipline or in a specific model of healthcare. In the monitoring of accredited programs, the AMC observes significant review and evolution of programs. The AMC's procedures for accreditation state: "the gradual evolution of a medical program in response to initiatives and review would not be considered a major change".
- Do requirements for planned accreditation reviews of proposed major changes inhibit change? The AMC believes that these processes can be managed so that they are not inhibitors of appropriate change. The AMC definition of major change to a program is more about structural change that affects the capacity of the education provider and program to meet the standards than about curriculum change, although it does also include comprehensive curriculum change and a change in program length. Where developments have been likely to affect more than one provider, the AMC has consulted on and implemented processes for effectively assessing the change across providers. For example, the introduction of rural clinical schools in Australia led to profound change in the location and quality assurance of clinical placements and in dispersion of medical education. The AMC developed a set of questions for medical schools concerning the rural clinical school development and the quality assurance of clinical training, and assessed the developments initially on paper through AMC's monitoring processes and then through the scheduled accreditation assessments.

In the discussion forums there has been discussion about the fear of triggering of a review occasioned by major changes in curricula potentially inhibiting providers from innovating. Under question 15, the AMC has given examples of teaching and learning innovations that have not been classed as major changes in the medical program. In a recent analysis¹⁴ of causes of AMC major change reviews, of the 18 major course changes requiring accreditation review, 5 related to a change of course length of a year or more, 5 related to a new site (3 onshore, 2 offshore), 3 related to introduction of a new 'lateral' graduate-entry scheme, 1 to introduction of a new joint program between two universities, and 4 related to a major change in curriculum or course. These are clearly all changes of sufficient magnitude to warrant the requirement of advance notice, and formal review before implementation.

- How do accreditation standards influence education programs to ensure graduates have the knowledge, clinical skills and professional attributes required of the current and future workforce? The AMC completes a major review of accreditation standards every five years. These reviews capture gradual change, for example in teaching methodology and norms, as well as specific changes (e.g. regulatory) which may affect a subset of the standards. Once standards have been established or revised, education providers begin reporting them in monitoring reports or accreditation submissions. Overall this setup allows changes in the environment (whether related to community, regulation or technology) to be reflected in the reporting on programs of study within a reasonable timeframe. In addition to standards revision, the other key to maintaining currency of standards is setting them at the right level, with an outcomes focus. Requiring providers to indicate how their program takes account of community need allow the assessment of programs to focus on the achievement of social goals, even if what those needs are and how they are addressed in programs of study may shift over time.

The introduction of the National Registration and Accreditation Scheme has made changing accreditation standards more difficult and has inevitably delayed some decision making.

AHPRA's Procedures for Development of Accreditation Standards, together with the requirement to consult the Office of Best Practice Regulation and to have standards developed by the AMC approved by the Medical Board of Australia makes minor revisions to standards less likely. In fact, the AMC has made no minor changes to accreditation standards since the National Scheme was introduced.

Interprofessional education, learning and practice

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

There has been work by accreditation councils on this topic, including jointly agreed definitions of inter-professional education (IPE) and inter-disciplinary practice from the Forum position paper in November 2015, as well as AMC's incorporation of IPE into its own standards. Reviews of competencies related to interprofessional practice also show widespread adoption in medical

¹⁴ Field, Michael J., Medical school accreditation in Australia: Issues involved in assessing major changes and new programs [J Educ Eval Health Prof.](#) 2011; 8: 6.

specialties¹⁵. The AMC has increased the emphasis given to IPE in accreditation assessments (with a specific accreditation standard concerning working and learning in interprofessional teams) with good practices commended to demonstrate that it is valued in accreditation. Through the Forum, the AMC continues to work with the IPE educational community in Australia to improve practices in this area.

An important enabler for taking adoption of IPE beyond the current level is government policy support and funding. Support for IPE has not been accorded the same priority as, for example, rural clinical placements (\$54.4 million allocated over 2016-17 to 2018-19 under the RHMT program¹⁶), but it is likely that for IPE, more could be achieved with less. In the UK for example, the 'New Generation Project' delivered IPE across 11 professions in a joint project between two universities with initial funding from the UK Department of Health of £3M¹⁷. Canada also made significant advances in this area through additional funding.

Clinical experience and student placements

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

The AMC's experience is that change in medical programs relating to healthcare priorities is driven by changes proposed by education providers themselves as well as change supported by Government and generally given additional funding (for example Commonwealth Specialist Training Program funding). Changes to clinical training requirements require engagement with the teaching health care services and health jurisdictions, and the creation of meaningful clinical experiences. The Scheme lacks mechanisms to engage in debates about these issues across the professions.

Health workforce priorities change, and are not necessarily consistent across the Australian states and territories. As the AMC indicated in its response to the 2014 Independent Review of the National Registration and Accreditation Scheme, in order to achieve directed and effective workforce reform, there needs to be clarity about health workforce priorities, and a decision-making process with authority over workforce planning and appropriate authority to undertake this task. This must be informed by broad based expert advice. Only with a clear workforce reform agenda can governments, national boards, accreditation authorities, education providers and health service providers work together in implementing their interlinked responsibilities for common objectives. No one player can drive or achieve reform, due to the interdependent roles and responsibilities of the various stakeholders.

How this might be managed with the National Registration and Accreditation Scheme is covered in the section on governance.

¹⁵ Braithwaite, J., Travaglia, J. (2005) The ACT Health inter-professional learning and clinical education project: background discussion paper #2. Inter-professional practice.

¹⁶ Ministerial announcement regarding RHMT: <http://www.health.gov.au/internet/main/publishing.nsf/content/rural-health-multidisciplinary-training-programme-framework>

¹⁷ Presentation on New Generation Project by Professor Debra Humphris, Pro Vice Chancellor Education October 2012 www.ipeforum.com.au/index.php/download_file/view/254/84/

The embedding of healthcare priorities within curricula and clinical experiences and outcome-based standards are not in conflict. A broad outcomes based approach enables individual providers to respond to the outcomes appropriate to their community and mission.

The AMC requires that education providers set objectives for their programs of study that take account of community needs and medical and health practice. It is up to the education provider to demonstrate how it assesses community need and changes in medical and health practice and how its curriculum responds to those needs and changes.

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

Contemporary education practices are incorporated in medical programs.

A review of AMC accreditation reports on assessments of primary medical programs over the last five years identifies a number of innovations in teaching and learning which have been commended by the AMC. These include:

- integration of lectures – captured live and using webcasting followed up in smaller sessions in a flipped classroom model, with students learning in small, interprofessional groups
- online interactive education modules to improve consistency in teaching in specific disciplines
- adaptive eLearning - a learning and teaching medium that uses an Intelligent Tutoring System to adapt online learning to the student's level of knowledge
- Near-Peer learning or vertical integration of learners in small groups of students who are one year apart in their medical education
- student-led multidisciplinary wards
- e-portfolios connected to curriculum outcomes to track and demonstrate appropriate exposure to disciplines and support personalised learning.

AMC accreditation reports also commend many innovative simulation developments, often building on Health Workforce Australia funding. For example:

- one report commends the variety of methods used to develop clinical skills, including role plays, simulated patients, and part-task trainers, to build up to learning in clinical attachments. Emergency scenario based simulation sessions are also conducted in the later years of the program
- a Clinical Learning through Extended Immersion in Medical Simulation initiative has been commended
- simulated patient programs are also commended in a number of AMC accreditation reports, although the logistics of coordinating and managing these programs are also acknowledged
- a Virtual Hospital development is commended.

The AMC is not prescriptive about the types or amount of simulation training or settings in which it should be used. Medical education is characterised by innovation in this area as in other areas.

Internationally, there is a move to accreditation authorities publishing good practice and innovation as a stimulus to further innovation. In 2017, the AMC is beginning a project to consider the logistics of managing such an approach.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

The period of supervised training after graduation from the primary medical program recognises the transition from student to practitioner. For medical practice, the need for supervised practice links to patient safety, integration of complex skills, and synthesis of knowledge with a clinical application. Internship allows medical graduates to consolidate and apply clinical knowledge and skills while taking increasing responsibility for the provision of safe, high quality patient care. Diagnostic, therapeutic and procedural skills, as well as communication, management and professionalism are developed under appropriate supervision. Internship also informs career choices for many graduates by providing experience in different medical specialties including general practice, and providing grounding for subsequent vocational training. These factors apply to differing extents across the NRAS professions, and the AMC is not in a position to comment on whether they warrant supervised practice as a precondition of registration outside of medicine.

The Medical Internship was reviewed as recently as 2014. While changes were proposed, the review did not suggest that the period of internship was unnecessary.

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

Work readiness should be defined through consultation between the stakeholders – National Boards, accreditation authorities, education providers, health services and other employers and the community. It should take account of data such as graduate outcome surveys, and readiness to practice surveys.

In 2017, the AMC hopes to begin work with the Medical Board of Australia on reviewing interns' perception of their readiness for practice that will help inform this discussion.

Definition of work readiness needs to be an iterative process. Readiness is likely to be multifactorial.

National examinations

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

The AMC has provided the process for accreditation of medical programs since 1988. There has been no national examination of doctors in Australia. There is evidence that the Australian medical graduates are of consistently high quality, at least when judged by performance in other countries' national assessments.¹⁸

Although the AMC believes that accreditation and national assessment can play a complementary role in ensuring that medical graduates have the knowledge, skills and professional qualities necessary for safe and competent practice, it is not clear that the benefits outweigh the considerable

¹⁸ Holtzman, K.Z., Swanson, D.B., Ouyang, W., Dillon, G.F., and Boulet, J.R., International Variation in Performance by Clinical Discipline and Task on the United States Medical Licensing Examination Step 2 Clinical Knowledge Component *Academic Medicine*, Vol. 89, No. 11 / November 2014

costs. There is currently no support among Medical Deans for a national licensing exam as an alternate to accreditation processes. Extrapolating from the current fees to take the USMLE exams per U.S. medical student, the cost in Australia of such an exam itself (not including requirements for student study time, travel expense and so on) would likely be in excess of A\$ 10 million per annum. Medical students already undergo numerous and rigorous assessments as part of their medical degree. We need to develop better ways of assessing performance of hard to test professional qualities and team-based work which are less amenable to testing in national exams, not necessarily adding more of the same at considerable expense. National exams may limit the range of areas selected/practical for large scale assessment and reduce innovation in favour of focus on the examination itself.

There are other models for enhancing consistency between medical schools' assessment practices. For example, the Medical Deans Australia and New Zealand benchmarking project with the AMC¹⁹ allows for collaboration in assessment and exploration of alternatives to a national exam model that, unlike national exams, would facilitate diversity and curriculum innovation. Both the US and Canada, which have national exams, also have rigorous accreditation processes very similar to Australia's.

Producing the future health workforce

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?

The appointment of profession members to a National Board has to meet requirements for membership from each jurisdiction. While AHPRA recruitment material does indicate the roles and skills expected of profession and community members, these are very general. An understanding of health profession education and training is not prominent in the skills requirements.

The Medical Board of Australia and the AMC understand their separate responsibilities in setting standards, accrediting programs and then approving the accredited programs. The Board has expertise in setting standards through its work setting and enforcing registration standards.

The AMC considers that it is part of its responsibilities as the accreditation authority to ensure that the Medical Board of Australia is well informed about plans for development of accreditation standards and that the Board has access to information and expertise to carry out its role in the approval of standards and programs. This is one of the AMC's accreditation functions under the National Law (Clause 42 (e)).

The question of whether there are incentives for National Boards to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system is a difficult one. As noted elsewhere there is limited reporting on performance expectation of Boards in this regard, and this could be enhanced.

¹⁹ <http://www.medicaldeans.org.au/projects-activities/assessment-benchmarking/>

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

The AMC agrees with the submission by the Health Professions Accreditation Collaborative Forum that the separation between the accreditation authority and National Board recognises the different focus, processes and structures involved in accreditation of programs of study and regulation of the profession and registration of individuals. Accreditation authorities and National Boards have separate specific knowledge and skills linked to their specific legal and regulatory tasks.

In our relationship with the Medical Board of Australia, there is clear respect for the AMC's expertise in developing standards and in making accreditation decisions. Currently, this relationship supports the nexus between registration and accreditation, which is critical to the Scheme. For this reason, the AMC does not see a need for greater independence of accreditation authorities, either in the development and approval of accreditation standards or the approval of programs of study and providers. If accreditation authorities were more independent in these matters, additional systems for communication and sharing between the National Board and the accreditation authority would need to be developed.

The AMC understand that its experience is not the experience in all professions. A whole-of-Scheme approach to setting accreditation-related performance expectations (see question 25) may help to clarify roles and improve relationships.

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?

The Quality Framework for Accreditation sets expectations of accreditation authorities regarding community input into accreditation governance, decisions and processes.

Under Domain 1, Governance, it requires

- The accreditation authority's governance arrangements provide for input from stakeholders including input from the community, education providers and the profession/s.

Under Domain 8, Stakeholder collaboration, it requires

- There are processes for engaging with stakeholders, including governments, education institutions, health professional organisations, health providers, national boards and consumers/community.

In line with an outcomes based approach, the accreditation authority must demonstrate that it has these arrangements and processes, and that they are effective.

The committee proposed in response to Question 25, with community representation, would add community representation in the monitoring of the performance of accreditation within the Scheme and in translating health and health workforce policy into accreditation processes.

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

Accreditation of programs of study, if it is to be of value requires professional expertise. This is the foundation of any peer review process. Without this input it risks being superficial and losing buy in and acceptance by the profession.

There are already substantial safeguards in place to minimise conflicts of interest, in terms of the Quality Framework for Accreditation, accreditation authority policies, and the provisions of corporations and charities commission law. Checks and balances also exist in the governance structures of individual authorities. For example, the AMC's governing body, the Directors, is informed by the Council and the Members of the Australian Medical Council are drawn from a broad range of the stakeholders in medical education and practice, including health consumer and community members, medical students and trainees.

23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

The AMC is a company limited by guarantee. It operates under the Corporations Act and the Australian Charities and Not-For-Profits Commission Act. The obligations on the AMC as a legally constituted company provide safeguards for the Scheme about the robustness and capability of the organisation to manage its functions, including its accreditation functions.

It is also a "for purpose" organisation. The objects of the company (listed in the introduction to the submission) are all related to its overall purpose which is ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. As was explained in the introduction to the AMC response to the discussion paper, the AMC has developed a number of processes and systems that support development in accreditation and assessment, and relate to our purpose but are not mandated by the National Law. The Scheme has benefitted from these additional activities and obligations.

Role of accreditation authorities

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

The AHPRA generated funding agreement acts as a basis for ensuring alignment with NRAS objectives, but it would benefit from a more developed performance management dialogue. Statements included unilaterally in letters to the accreditation authorities, without formal discussion about their wording, the capacity to achieve the expectations described or the reporting on achievements have not been not helpful. The AMC accepts that there is a willingness to improve these processes.

The current framework is still evolving, and work done between the accreditation authorities and AHPRA in 2016 to clarify timelines and negotiation of agreements will assist in this regard. There is scope for more explicit performance indicators (see under Question 27) and for a more substantial dialogue regarding the performance of accreditation – not just accreditation authorities - against those indicators.

What other governance models might be considered?

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

Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;

Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

The AMC believes the current model works with respect to the bulk of the work of accreditation. This work entails maintaining processes, standards and operating procedures to enable making accreditation decisions within the National Law about a specific program of study in a specific health profession and assessing an overseas trained health practitioner's knowledge and skills to practise in a profession in Australia. From an operational point of view, the AMC is focussed on medicine. Our accreditation model is based on close cooperation with the profession, and being able to draw on our extensive network to complete work and to respond in an agile fashion to changes in the regulatory and policy environment.

The type of governance model which has evolved to serve medical program accreditation (including assessment of international medical graduates) encourages focus and specificity. It attracts people at the peak of the profession who are concerned with strengthening education foundations. It is accountable through regular reporting to the National Board. Whatever governance model is recommended for the accreditation functions in the Scheme as a whole, these characteristics need to be preserved. They have supported the considerable success of the current model.

It follows that the AMC does not support the proposal for a single accreditation authority. It is not clear that the work entailed in creating such a structure will lead to improved outcomes or enhance the innovation currently possible in medicine. It points to developments in the HCPC in the UK. The UK social workers are due to leave the HCPC by 2020 and set up their own accreditation/regulation body, with UK Education Secretary Nicky Morgan citing "a relentless focus on raising the quality of social work" as part of the reason. A letter from the UK Department of Health to the HCPC outlining the circumstances surrounding the decision refers to the need for a "different model of regulation, one that is specific to this unique and challenging profession". Amalgamated models appear to constrain the focus and specificity required for health profession accreditation. The constraining factors include bureaucracy, the need to dilute standards to fit multiple professions, and the inability to attract the best accreditation talent to an organisation with a generic remit.

In the NRAS governance structure, accreditation is somewhat separate to the bulk of the work of the Scheme which relates to regulation of health practitioners. In the early days of the Scheme this allowed each accreditation authority to work closely with their National Board to integrate accreditation processes into the Scheme. Accreditation draws lightly on the Scheme's resources that support the regulation functions.

As the Scheme has developed, mechanisms have developed to address the need to bring together professions and entities to facilitate communication, share good practice and address common problems in accreditation.

The Health Professions Accreditation Collaborative Forum is one such mechanism. It is not funded by the Scheme but by the individual accreditation authorities, with the AMC providing the majority of the support.

The Accreditation Liaison Group, which has membership drawn from AHPRA, the National Boards and the accreditation authorities, was established by consensus to address common accreditation-related concerns and developments within the Scheme. It brings together the three groups that all have accreditation-related responsibilities under the Scheme.

The AMC agrees with the Forum that a potential solution to the challenge of carrying out the accreditation functions provided in the National Law while progressing cross-profession issues is to build on the existing Accreditation Liaison Group, and give that group enhanced status and expanded membership. The AMC sees this providing a coordination group to allow for Scheme-wide initiatives cross profession initiatives and discussion and action on health workforce policy. It would need representation from all three major types of organisation within accreditation roles in NRAS: National Boards; accreditation authorities; and AHPRA, as well as community representatives, education providers and possibly also health policy advisors. Such a group would be able to reflect the requirements for intra- and inter-professional coordination by nature of its representation. It would have accountability for progressing cross-profession issues, and would be accountable to the AHPRA Agency Management Committee, and thus to ministers through a transparent process.

From the AMC viewpoint, this committee should have the following characteristics:

- The new body should be a committee, and not a board. The Government has expressed an interest in reducing, rather than increasing, the number of statutory bodies associated with health policy and regulation.
- The committee should be located within the NRAS scheme and funded by it. Accreditation is a specialised area, and it is served best by governance in proximity to National Boards and AHPRA, as well as to the accreditation authorities themselves.
- It should have an independent chair.
- It should include representatives from National Boards, accreditation authorities and AHPRA, each of which has a role to play in policy and governance.
- It should include representatives from education providers, community representatives and health policy input.
- It should have a clear channel of communication with ministers, through a formalised dialogue. It should have the authority that derives from its communication with ministers and their expression of policy priorities.
- It could be a mechanism to set priorities and allocate funding to support cross profession initiatives and projects.

The Review asks if AHPRA's Agency Management Committee might be a vehicle for managing cross-profession issues. 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.

Given that AHPRA itself has accreditation-related roles, it does not seem transparent to give the Agency Management Committee direct responsibility for managing cross profession issues. A committee charged with that task needs to be fit for purpose, and include the appropriate skills and incentives to fulfil that purpose.

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

There is not a clear mechanism for dealing with these issues now and the National Law is silent on these issues. It focusses on the linkage between regulation of a specific profession and accreditation of programs and assessment of overseas trained practitioners in that profession.

This does not mean that the Scheme cannot develop mechanisms to support recognition and accreditation of cross-professional competencies and roles, but it does mean that there is no clear mandate for them or process for resourcing them.

The Forum progresses issues through workshops, working groups and stakeholder consultations. However, currently accreditation standards must be approved by the National Board for the profession. Without a mechanism for cross profession agreement within the Scheme, cross-professional competencies will need to be handled within the framework of accreditation of individual professions.

The mechanism proposed in answer to Question 25 would address cross profession coordination.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

The National Law gives three types of entities responsibility for delivery of accreditation functions: the accreditation authorities, the National Boards and AHPRA. The Quality Framework for Accreditation (2011) is the agreed statement on the domains for reporting on the performance of one group – the accreditation authorities.

The AMC supports accountability for actions and decision and use of resources. It has demonstrated its own interest in external evaluation and review of its performance and commitment to improvement through international peer review and benchmarking.

Within the National Scheme, the performance of each profession-specific accreditation authority is overseen by a National Board and the AMC reports to the Medical Board every six months against the domains of the Quality Framework for Accreditation. In addition to a qualitative report on governance structures and processes, and the development of accreditation processes and functions, the AMC provides data and information such as audited financial statements, a forward work plan and a list of completed accreditation decisions, plans to review standards, data on numbers of overseas qualified health practitioner assessed and the assessment outcomes, information on complaints received and their outcomes.

The AMC has considered the performance measures and data collected in the Professional Standards Authority (United Kingdom) assessment of the UK-based regulators against the reporting requirements of the National Registration and Accreditation Scheme. Within the UK reporting system, quality assurance of education and training is a small component of the overall report by regulators, and the Australian requirements in the Quality Framework for Accreditation seem to be more specific to assessing the performance of accreditation authorities. The UK process results in more visible reporting, however.

The Quality Framework does not contain domains for assessing the work of AHPRA or the national boards and the AMC is not aware of any reporting by National Boards or AHPRA explicitly on their

performance in relation to the accreditation component of the Scheme. If a committee was established along the lines discussed in our answer to Question 25, it could oversee the performance of AHPRA and National Boards in accreditation.

Setting health workforce reform priorities

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

The response to question 25 proposes a high level committee within the Scheme that would act as a bridge between the implementation and delivery of accreditation services, and Ministers and health policy.

Under this arrangement, Ministers could be briefed on the accreditation authorities' findings concerning the trends and developments in health profession education, and could seek or provide advice on health workforce policy and its implications for accreditation and for health profession education and training.

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

The direction under s11(3)(d) and s11(4) have an additional clause not included in the question. This clause requires that the Ministerial Council first given consideration to the potential impact of the Council's direction on the quality and safety of health care before it issues a direction on the basis of substantial and negative impact on the recruitment or supply of health practitioner. This clause was the subject of significant discussion when the Scheme was being developed and canvassed in consultation papers during 2008. The addition of that clause was considered essential so that health workforce recruitment and supply considerations did not override safety and quality.

The full clause is considered sufficient, given that the AHPRA Procedures for Development of Accreditation Standards require:

- accreditation authorities to consult governments on proposed new standards
- that development of accreditation standards takes into account the objectives and guiding principles in the National Law. It is up to the accreditation authority to demonstrate how it has done this when it presents revisions to the standards or new standards for approval.

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

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

Australia does not have a centralised system of health care accountability²⁰. AMC experience in consulting health jurisdictions when 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 patterns, it means accreditation authorities can find it challenging to determine which policies should be accorded priority. For medicine, the National Medical Training Advisory Network could potentially provide a national focus for discussion of national medical workforce reform objectives.

There also needs to be a mechanism in the National Scheme for linking this national focus to accreditation and health profession education and training. The response to question 25 sets out a proposal for a committee within the Scheme that would provide this linkage and builds on the already functioning Accreditation Liaison Group.

Good policy requires more than appropriate decision-making structures. It involves, for example, prior to the policy decision, analysis of the existing situation, generation and evaluation of policy options, and subsequent to the decision, planning of policy implementation, and policy impact assessment, and so forth. Health Workforce Australia's work program addressed some of the necessary activities such as research on the health workforce, which provided a basis for policy generation, and programs such as integrated regional clinical training networks, which supported policy implementation. These activities came at a cost, with a final year government contribution of around A\$150M. Some elements of HWA's work program are still active and can be drawn upon for policy purposes.

Accreditation authorities recognise that they carry part of the responsibility for developing this policy infrastructure. However with a total budget of A\$16M for NRAS accreditation activities (not including overseas trained practitioner assessment), this contribution will necessarily have its limitations.

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

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

Yes. The AMC would argue that there are standards and accreditation processes to provide scrutiny of these operations and the performance of these functions.

²⁰ OECD (2107). Caring for Quality in Health – Lessons Learnt from 15 Reviews of Health Care, p9. <https://www.oecd.org/els/health-systems/Caring-for-Quality-in-Health-Final-report.pdf>

The AMC accredits specialist medical programs against the Standards for Assessment of Specialist Medical Programs and Continuing Professional Development Programs. These standards address the quality, breadth and supervision of training in health services, including the way colleges quality assure that training. The AMC revised these standards in 2015. The standards concerning college accreditation of posts and training programs have been strengthened²¹. The AMC deliberately brought standards into alignment with the Australian Health Ministers' Advisory Council Health Workforce Principal Committee, *Accreditation of Specialist Medical Training Sites Project Final Report*, 2013. These changes are new, and it will take some time for them to be worked through.

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 on 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. It is not accreditation of a program of study under the National Law but links to registration requirements. The domains the AMC uses to assess intern training accreditation authorities build on the domains of the Quality Framework for Accreditation (used to assess National Scheme accreditation authorities). AMC accreditation of intern training accreditation authorities began in 2013.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

As the discussion paper point out, 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. The Medical Board of Australia is nominated as the assessing authority for medical practitioners on the Consolidated Sponsored Occupations List managed by the Department of Immigration and Border Protection. Prior to registration applicants must undergo assessment conducted by the AMC.

33. Is there is a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

No. Accreditation authorities have access to the necessary expertise for these assessments through their links with education providers and their international links. In fact, development and maintenance of expert networks is a core capability of accreditation authorities. In general an economy of scope applies between accreditation and the assessment of overseas trained practitioners, creating synergies. Separation of these functions is likely to result in a less efficient economic outcome. We note that this question suggests that the reviewers see a synergy between setting standards for education programs and assessment functions (which the AMC supports).

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

²¹ See section 8, http://www.amc.org.au/files/059c6d1dee49caa6c434c18138f6373fb4be8b36_original.pdf

Given the wide diversity 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. Assessment must be fit for purpose, depending on the profession, and on the skills, knowledge and attributes that should be assessed.

Similar assessment methods are used across a number of professions.

The choice of assessment pathway will depend on the resources available to support the assessment. In the case of medicine, the workplace-based assessment (WBA) pathway has been shown to be effective in measuring performance, and not merely competence alone. It also enables the upskilling of international medical graduates over time and is an effective mechanism for integration of the IMG into the Australian medical workforce. However, limited opportunities for WBA placement mean that this pathway will only be available to a limited number of candidates each year.

More important than consistency across all professions is that the assessment processes adopted 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.

35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

The supervised practice requirement in medicine was originally implemented in recognition of the fact that the available screening processes and examination for international medical graduates could not identify all aspects of performance critical to safe practice, such as professional attitudes. It was considered that in high risk disciplines, these issues could only be identified in the workplace setting.

The AMC's experience with pathways for international medical graduate assessments, specifically the Workplace Based Assessment pathway and previously with the Competent Authority pathway (between 2008 and 2014) confirms that personality and attitudinal problems were identified in the workplace that were not picked up in the formal assessment of the IMGs concerned.

The introduction of the National Registration and Accreditation Scheme allows, for the first time, national registration standards and requirements for international medical graduates. The Medical Board of Australia has access to increasing data on the impact of these registration requirements – supervision guidelines, periods of mandatory supervised practice. The AMC expects that standards and guidelines in this area will continue to evolve based on analysis of this data.

The requirement that all international medical graduates who present for the AMC examination undertake a period of supervised practice will be reconsidered in the light of the data that is now being captured from the AMC multiple choice and clinical examinations, to establish whether it may be possible to fast track certain candidates into general registration on the basis of their performance without the requirement for supervised practice. This may require re-design of some assessment components of the examination and redefinition of the assessment standards.

The current pathway for overseas trained specialists includes a period of working “under peer review” for those doctors who have been assessed as “substantially comparable” to an Australian trained specialist in the same specialty field. There appears to be some inconsistency in the way this provision is implemented – ranging from a short period of “oversight” to 24 months of workplace-based assessment. This situation needs to be scrutinised more closely.

Grievances and appeals

36. Does the AHPRA/FORUM guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

37. If an external grievance appeal process is to be considered:

Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?

Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

The AHPRA/Forum guidance document addresses complaints about accredited providers and programs. The AMC has revised its complaints procedures based on this guidance and considers that it has clearer and more transparent processes as a result. Complaints addressed through this mechanism as systemic issues that may identify areas where standards are not being met.

The Quality Framework for Accreditation has requirements about managing complaints about accreditation functions. Under Domain 5, Processes for accreditation of programs of study and education providers, it requires

- There are published complaints, review and appeals processes which are rigorous, fair and responsive.

The AMC report every six months on complaints received (both about the accreditation programs and providers and, if any about the AMC's processes) and the outcomes of them.

The AMC strongly believes that as a quality assurance body, which requires accredited providers to demonstrate a commitment to continuous improvement, it must have rigorous processes for addressing complaints and using the findings from complaints to improve its processes.

The AMC seek feedback from providers and assessment teams after each accreditation assessment. Negative feedback triggers an internal review and, if the AMC thinks it necessary, the appointment of an independent reviewer to consider the outcomes of the AMC's internal review. Recently, the AMC and one of the other accreditation councils have collaborated by making available an independent reviewer (from outside the profession) to address a complaint. This is one of the models that could be used more widely.

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.

Australian Medical Council

May 2017