SUBMISSION TO THE COAG HEALTH COUNCIL AUSTRALIA'S HEALTH WORKFORCE: STRENGTHENING THE EDUCATION FOUNDATION

April 2019

INTRODUCTION

Universities Australia (UA) welcomes the opportunity to comment on the COAG Health Council's recent consultation paper: Australia's Health Workforce: strengthening the education foundation. The paper lays out the thirty-two recommendations from the final report of the Accreditation Systems Review (ASR) of the National Registration and Accreditation Scheme (NRAS). UA has previously provided verbal and written feedback and two formal submissions to the original ASR. Our support for the draft report's recommendations, to which the final report recommendations are comparable, were provided in our submission to the ASR in September 2017 (attached).

UA understands that the focus of the current consultation is on the costs, benefits and risks of implementing the final report recommendations. Our submission is limited to those areas within UA's scope as a national peak body for Australian universities. The submission has been developed in consultation with UA's Health Professions Education Standing Group (HPESG) which represents all health professional disciplines taught in universities across all jurisdictions.

COSTS

UA is unable to comment on the costs of implementing the report recommendations overall. However, it is UA's view that, without the implementation of many of these recommendations, there will continue to be inefficiencies, opacity and the potential for unnecessary and inequitable accreditation costs to education providers and to the system more broadly. Implementing some of these recommendations will require considerable time and resources. This upfront work is a necessary investment in removing duplication and developing a more efficient, effective, transparent, accountable, consistent and future-facing accreditation process. UA notes that work on several priority areas has already commenced and supports a phased, priority-driven approach to implementation. UA also notes that some elements of the recommendations (for example, the use of accrual accounting and other processes outlined in recommendation 1) already constitute good practice and should therefore largely be in place, so reducing implementation cost.

UA supports implementation of the report's first six recommendations regarding *"Funding and cost effectiveness"* (recommendations 1 to 3) and *"Improving efficiency"* (recommendations 4 to 6). These recommendations lay out sensible ways in which to address a number of ongoing accreditation concerns including:

- reducing duplication/regulatory burden and increasing efficiency through greater clarity between professional and academic accreditation and the provision of common reporting frameworks for education providers;

- increasing transparency and accountability through developing accreditation funding principles;

- supporting quality assurance of the accreditation scheme though the development of various indicators; and

- greater consistency through enhanced accreditation assessment team preparation.

There is also broad support for recommendations 7 to 14 (*"Relevance and responsiveness of education"* – see UA's previous submission for further detail and caveats). These recommendations include a focus on:

- consumer involvement in health professional education design;

- greater emphasis on risk and outcomes-based approaches;

- the encouragement of agreed definitions for inter-professional education (IPE) and;

- the facilitation of team-based approaches – one of several priority areas that the Australian Health Practitioner Regulation Agency (AHPRA) is progressing.

A number of these recommendations are likely to require more limited resources to achieve their outcomes – with two exceptions:

- Recommendation 10 - the development of standard definitions and terminology across disciplines and accreditors; and

- Recommendation 12:

  a) the expansion of clinically relevant placements to a broader range of settings; and

  b) use of evidence-based technological advances in the curricula and pedagogical innovations in program delivery.

UA strongly supports recommendation 10 while acknowledging the time and resources required to develop agreed standard definitions and terminology. Consultation with relevant stakeholders, including education providers, will be essential to implementing this recommendation however UA views the efficiency gains from this work to be worth the investment.

UA also supports recommendation 12 and sees both elements referred to as important contributors to clinical education, skills development and workforce distribution. However, in relation to point a) above, past experience has shown that expanding placements to broader, non-traditional settings often requires significant time and resources to develop. There are a number of structural disincentives to expanding placements, particularly in areas of identified workforce growth such as aged-care and disability services as well as in small business settings like general practices and allied health practitioners' and medical specialists consulting rooms. If such expansion is to be achieved, UA recommends that it occurs as part of a broader workforce planning approach and that resources are made available to both education and service providers, to support its effective implementation.

Similarly, in relation to point b) above, UA supports innovative approaches to teaching and clinical education. Some of these incur only small additional costs however those underpinned by technology (such as high-fidelity simulation, the use of augmented/virtual reality and/or AI and the like) can incur significant upfront costs (infrastructure, equipment and staff training) which can constrain their implementation and use. UA suggests that where new technology is recommended for use by education providers or incorporated into best practice/accreditation standards, a cost/feasibility study accompanies the recommendation. Above a certain threshold - determined in conjunction with education providers – use of the proposed technology should be optional and/or funding options to support its installation should be made available through relevant Health/Education departments.

UA also broadly supports recommendations 15 to 24 which outline foundation accreditation governance principles as well as governance approaches for more efficient and effective accreditation. However, the following two qualifications are made (see also UA's September 2017 ASR submission for important qualifiers on these and other related recommendations):

- UA gives in-principle support for the separation of responsibilities for accreditation of health professional education courses from registration/regulation of individual practitioners (recommendation 15) but supports ongoing collaboration between the entities governing these two distinct, but related functions.

- UA gives qualified support for the implementation of the Health Education Accreditation Body (HEAB - recommendation 19). This remains UA's preferred option subject to the qualifications outlined in UA's previous submissions to the ASR[1].

The HEAB, if established, appears to provide greater opportunity for connecting accreditation with health workforce development goals to take a more responsive whole-of-systems approach than might be possible through expanding the functions of the current AHPRA Agency Management Committee.

It is recognised that establishing the HEAB has associated costs. UA notes the economic analysis in the ASR reports regarding these costs and sees this as a small investment - but a critical step - in bringing Health, Higher Education and others together for improved governance around accreditation and health professional education that is potentially better linked to workforce planning and need.

UA also notes that the AHPRA Agency Management Committee has recently established an Accreditation Advisory Committee to provide whole-of-scheme perspectives on accreditation issues to support progress of the ASR's final report recommendations. UA welcomes the opportunity to be part of this committee, as proposed in the current consultation paper.

UA has no comment to make regarding costs of recommendations 25 to 32, few of which are directly relevant to universities.

BENEFITS

UA sees implementation of the report recommendations as beneficial to multiple stakeholders. They support high quality, transparent, efficient and effective professional accreditation approaches connected to future health workforce and skills development. This has all-round benefit – to professions, to consumers, to educators and to health service providers. UA recognises that resources are required to implement the recommendations, more so in some cases than others, but reiterates that this is an important investment in developing a safe, quality, health professional workforce with the skills, knowledge and experience to adapt in a timely way to changing population/community health needs and evolving models of care. If implemented, benefits would include:

- Greater transparency in accreditation costs, a greater emphasis on cost recovery approaches, more consistency in, and easier comparison of, the costs charged to universities by different health professional accreditors, and greater overall accountability around accreditation.

- Increased efficiency and reduced duplication of effort through:

    – clearly delineating academic from professional accreditation;

    – standardising terminology and information sharing across accreditation processes and professional domains, while retaining relevant discipline-specific elements;

    – adopting a harmonised approach through development of a common reporting template;

    – moving to risk and outcomes-based assessment and accreditation processes where feasible;

---

[1] It is also the preferred option, with qualifiers as described, of all HPESG Council of Dean members except the Medical Deans Australia and New Zealand.

- enhanced preparation, training and monitoring of accreditation assessment teams; and

- potential future amalgamation of health professional accreditation bodies.

- Greater system benefits through increased consumer involvement in education/training and further embedding patient-centred, cross-professional, team-based, culturally appropriate approaches in curricula.

- Stronger links between accreditation, health professional education and future workforce development through the proposed policy review process and a statement of expectations identifying health workforce directions and reform.

- Clearer and more manageable governance processes through development of either the HEAB or HEAB activities undertaken by the AHPRA Agency Management Committee and by separating responsibilities for accreditation from those of registration while still enabling requisite collaboration between these two elements.

- Reinforcing and strengthening the quality and safety aspects of care delivery and health professional workforce development through incorporating the NQSHS Standards into accreditation measures and by further emphasising the use of principles-based, good-practice approaches as the foundation for standards, competencies and accreditation processes.

- Greater clarity regarding whether recommended additional postgraduate education and training is part of a genuine need for general registration or part of workplace development. Where the former is agreed, then such education will be as defined programs of study requiring relevant accreditation.

While the focus of the ASR has always been the NRAS professions governed under the National Law, many of the recommendations are highly relevant to non-NRAS profession accreditation bodies. UA supports recommendation 24 regarding access by the self-regulating professions to the skills and expertise of the national accreditation scheme. It is a further benefit and a way to promote more transparent, accountable, standardised, best-practice accreditation across all health professions.

It is out of scope for UA to comment on recommendations 25 to 32 in their entirety as not all are directly relevant to higher education providers/universities. However, UA strongly supports, and sees benefit in, recommendations 31 and 32 regarding, respectively:

- development of a national health workforce strategy; and

- regular statements from the Australian Health Workforce Ministerial Council (AHWMC) regarding key workforce directions/reforms and expectations relevant to regulator performance and national scheme entities.

In the absence of a national health workforce policy it is difficult for UA members to align health professional education with national requirements for health workforce development. National health workforce goals and best-practice evidence about strategies to develop the future workforce should be incorporated into accreditation processes.

RISKS

A number of the recommendations require resources to implement. Where these are significant, there is a risk that implementation will not commence or will not be completed. This is a key risk in UA's view and risks losing the opportunity to bring about the practical and effective reform to the accreditation system that the ASR has described. UA supports a phased, priority-driven approach to full implementation over time and acknowledges the work that has already commenced on progressing several recommendations.

Consideration about how, and by whom, recommendations are implemented and resourced will also be required, especially where these fall outside of the obvious remit or realistic economies of a particular stakeholder. A number of recommendations may require funding and/or other support to establish with

more limited recurrent funding to maintain. Others, such as those identified in recommendation 12 above, will need significant, sustained resourcing and UA urges consideration of ongoing joint Commonwealth and State government funding to achieve the important goal of expanding placements to non-traditional settings.

A further risk to implementing the recommendations occurs if legislative or regulatory change is needed and and/or where implementation may add to administrative burden. One such example is the establishment of the HEAB which would require change to the National Law. There is also a risk that the HEAB could become overly bureaucratic and removed from relevant stakeholder input. While it is critical that the recommended accreditation governance reforms are implemented and UA is broadly supportive of the HEAB, UA recognises that assigning these responsibilities to an expanded AHPRA Agency Management Committee may be a more practical initial approach or could be used as a first, temporary step to progressing the report recommendations.

It is essential that whichever mechanism is selected as the avenue for accreditation governance reform, it must: remain sufficiently independent of, but closely linked to, the COAG Health Council; comprise the necessary higher education and other expertise; enable effective avenues for stakeholder and discipline-specific input and; remain responsive to rapid workforce development and the need for this to be communicated to/translated within health professional education - and the health system more broadly.

Lack of workforce planning in Australia poses real risks to ensuring a responsive accreditation and health professional education system that is aligned with health workforce needs. Several of the ASR report recommendations help lay the foundations for this and are welcomed. UA continues to recommend that in addition to this, an enduring mechanism that connects relevant stakeholders and different levels of government in Health and Education is needed.

CONCLUSION

The ASR has taken a comprehensive approach to addressing some of the ongoing challenges in relation to health professional accreditation and offers options for governance reform to oversee continued development of effective accreditation processes. UA broadly supports the ASR recommendations, with some qualifications. Their implementation is an opportunity to make significant progress. UA understands the resources required to implement the recommendations fully and supports a priority-driven, phased implementation approach. UA welcomes the opportunity to be included on the AHPRA Accreditation Advisory Committee and invites the COAG Health Council to talk further with UA and UA's HPESG regarding implementation of the ASR's final report recommendations and ongoing health workforce and health professional education matters.