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AMA Submission: Independent Review of Accreditation within the National Registration and Accreditation (NRAS) Scheme Draft Report

The AMA welcomes the opportunity to make a submission to this review.

Summary

The AMA has consistently called for health workforce reform to be developed and managed outside the national scheme. It is imperative in order to maintain the confidence of the professions regulated under the scheme, that policy development in this space is completely independent of the accreditor and regulator.

The AMA strongly opposes scope creep by other professions and requests the governance and regulations around accreditation support vigorous analysis of any proposed changes to the professions standards.

The AMA is satisfied that the accreditation arrangements under the NRAS have met the broad expectations of the medical profession. The accreditation functions, which in relation to medicine the AMC has been able to demonstrate, are less costly than other countries, are thorough and provide an assurance to educators and students that there is an accepted standard across Australia. A standardised accreditation function across the whole of the scheme is not supported.

The AMA does not support other health practitioner groups, or health care workers, joining the scheme, or part of the scheme, merely to enjoy a perceived status and credibility of being regulated by the scheme. Only those that have a scientific basis to their practice should be included in the scheme.

Finally, the governance of the scheme should ensure that AHPRA is sufficiently accountable to the professions that fund it. There is a growing concern within the profession that the current accountability mechanisms are not consistent with the provision of a viable national system, and that as a result there are unintended and longstanding impacts on doctors which may be having a deleterious effect on their careers and wellbeing.

Introduction

Australia has a world class health system that delivers very good outcomes for patients. The results achieved are, in large measure, the product of a high skilled health workforce that is responsive to community need and committed to innovation and continuous improvement.

Medicine is an excellent example. The Australian Medical Council (AMC) is highly regarded both here and overseas and had the led the way in developing, modern, outcomes based standards

for medical education. These incorporate competency based training and assessment, inter-professional learning, the role of simulation, training in expanded clinical settings and recognise the importance of an assessment of community need within accreditation arrangements. The AMC also has strong consumer input, which has flowed down to the various training programs accredited by the AMC.

We also know that the AMC is sharing its expertise with other accreditation bodies and this is helping to lift the standards of training and education within other professional groups.

Unfortunately, the Review fails to recognise the innovation and reform that is already happening within the health workforce as well as the proven record of accreditation bodies in establishing frameworks that support high quality training and education.

The Review studiously avoids this inconvenient reality and many of its key recommendations simply look like an attempt to address unfinished business arising from the *2005 Productivity Commission Review of Health Workforce*, which is not surprising given that the Independent Reviewer also led that work. A great deal has changed since 2005, including a significant expansion of the medical workforce and other health disciplines. We do not need to revisit concepts that were rejected in 2005 and are of even less relevance today.

The AMA also rejects one of the fundamental premises on which the Review bases its findings. The draft report clearly implies that growing health care costs are driving the need for reform. Yet, we know that health spending in Australia sits around the OECD average as a share of GDP. We also know that Commonwealth health expenditure is actually reducing as a percentage of the total Commonwealth Budget. In the 2016-17 Federal Budget, health was 15.8 per cent of the total, down from 18 per cent in 2006-07.

We also suggest that the Review has put too much emphasis on concerns about duplication within current accreditation arrangements and processes. By its very nature, the accreditation of health workforce training will always involve some complexity and there will be stakeholders who object to this.

However, the safety of the public is paramount and there are also acknowledged and legitimate differences between health professions and within health professions. Seeking to impose a one size fits all approach to accreditation in terms of governance, standards and process does not reflect the reality of health workforce training or the context in which it is delivered. Instead, it will undermine the confidence of both the public and health professions alike in accreditation arrangements.

In the AMA's view, the Review has not made the case for substantial reforms to accreditation arrangements, particularly in relation to their governance. The Review presents no evidence that accreditation bodies are acting in a way that is inconsistent with accreditation functions specified under the national law. The Review's preferred changes to governance arrangements will simply increase bureaucracy, cost and undermine the independent, professional led arrangements that have served Australia very well.

Comments on specific proposals

The relevance and responsiveness of education

Australia's medical accreditation arrangements are among the best in the world, and is used as an exemplar by other countries in developing their systems.

The AMC, as noted earlier, has already implemented outcomes based standards. Through regular updates of its own standards as well as cyclical reviews of medical schools, post graduate medical councils and medical colleges, we are seeing the adoption of best practice standards of education and training in medicine.

With respect to mandating requirements for clinical placements in a variety of clinical settings, we note that in both undergraduate and postgraduate medical education the utilisation of expanding settings is increasing. However, it must be recognised that there are clear limits on the extent to which this is possible including funding, infrastructure, supervision and the quality of the clinical experience. While this should be a desired goal, for the reasons outlined, it should not be made mandatory on a one size fits all basis.

We also note that the Review targets requirements for general registration additional to the attainment of an undergraduate qualification. In relation to medicine, the internship is a foundation year of work-based learning that culminates in general registration to practise medicine. It is a key part of the transition period between medical student education and career development in a chosen specialty.

The well-rounded generalist orientation provided by the intern year enables junior doctors to develop, through practical training and experience, the professional knowledge and skills which will underpin their medical career and ready them for the specialist vocational training offered by medical colleges.

Accreditation Governance

The introduction of National Registration and Accreditation Scheme in 2010 represented a very significant reform to the governance of health workforce accreditation arrangements. While the AMA expressed significant reservations about NRAS, medicine has been fortunate to the extent that it already had robust registration and accreditation arrangements in place and these have proven to be an exemplar for other professions within the NRAS.

The AMA believes it is too early in the life of NRAS to consider significant reforms to the governance of accreditation and a more cautious approach is warranted, focusing on measured changes to address circumstances where there is clear evidence of a failure in accreditation arrangements.

In the AMA's view, asking accreditation bodies to take a more active role in health workforce reform is a distraction and, in many respects, incompatible with their fundamental purpose. Consistent with their current function, they should continue to focus on developing a highly skilled health workforce. The AMA does not support the establishment of a new Health Education Accreditation Board (HEAB) nor the assignment of accreditation functions to committees established under the HEAB.

To the extent that greater collaboration is needed between accreditation bodies on matters such as accreditation processes and inter-professional learning, then this is something that could easily

be facilitated through the existing Health Professions Accreditation Collaborative Forum (HPACF). We note that that the HPACF operates with almost no resources and, to this extent, will require additional support if it is to undertake this role effectively.

The AMA does not support a structure which seeks to increase the role of government in setting the standards, policies and procedures affecting the education and training of Australia's medical profession.

Addressing health workforce reform

With respect to workforce reform, the AMA strongly believes that this should be dealt with outside of the NRAS. In our submissions to the 2014 NRAS Review Consultation Paper, the AMA identified the need for an independent entity to be set up to assess and evaluate health workforce needs in the context of the health needs of the Australian community and the expenditure on health that the Australian community is prepared to pay.

Within that structure, expanded scopes of practice could be assessed to determine that:

- the required competencies are predetermined and accredited training and education programs are available to deliver those competencies;
- there are documented protocols for collaboration with other health practitioners;
- there are no new safety risks for patients;
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

The AMA specifically proposed that the assessment group should comprise the following members:

- a Chairperson who is a non-practising clinician;
- a specialist general practitioner;
- a specialist medical practitioner;
- a nurse;
- a former President of a Medical College;
- a community member; and
- a health economist.

A member of the health practitioner group that is the subject of the assessment would be a temporary member of the assessment group, as would any other registered health practitioner group that would affected by the proposal.

The independent entity and the assessment group should have appropriate administrative support and be able to access specific clinical and health economic expertise as required. The assessment group should be able to receive proposals for expanded scope of practice, and initiate assessments where necessary. All assessments by, and advice of, the assessment group should be made publicly available.

Because of the impact on health budgets and the implications for the safety and quality of the Australian healthcare system, this assessment and evaluation process should be funded by

governments. It is not necessary to have a legislative basis for this entity. There are several examples of non-legislative entities that are jointly funded by all governments.

While Health Ministers would be responsible for appointing the members, its independence would be secured through the public reporting mechanisms described above and not to the Health Ministers. This would mean that Health Ministers, in ignoring the advice of the independent entity, would be taking a political decision to do so.

The AMA seeks that this review recommends an independent authority is established to provide the appropriate advice to Health Ministers on health workforce reform to ensure Australia develops the health workforce it will need. It is not reasonable to ask the regulator to provide this policy advice. It would create a perceived, if not real, conflict of interest.

Other governance matters

Assessment of International Medical Graduates

There has been significant reform to the assessment processes for IMGs over many years, with the Medical Board of Australia (MBA) working closely with the AMC and medical colleges to streamline process and adopt transparent and objective standards. We expect that the MBA will continue to pursue improvements in this area, working collaboratively with stakeholders. From the AMA perspective, compared to ten years ago, we see very few complaints from IMGs about assessment processes. This provides us with significant comfort that reforms are having a positive impact and that the Review is overly concerned with this area.

Applying the National Law to medical colleges and postgraduate medical councils

The AMA does not support this proposal. AMC accreditation standards already place significant requirements on these bodies in terms of transparency, credible assessment methods, appeal mechanisms and the like. These appear to be well accepted by the profession and the AMC through its cyclical reviews and complaints policies is able to address concerns about the delivery of training by training providers.

Postgraduate medical councils and colleges rely on a significant pro-bono contribution to deliver training and do so at a relatively low cost. Placing additional legal requirements on PMCs and colleges will create a more litigious environment, drive up the costs of training and potentially discourage Fellows from contributing to this critical activity due to a heightened fear of litigation.

Expanding the scheme to unregistered professions

Recommendation 26 suggests that governments should allow unregistered professions to access the 'skills and expertise' of the Accreditation Board.

This is a 'thin end of the wedge' attempt to expand the scheme to other professions. The AMA does not support other health practitioner groups, or health care workers, joining the scheme, merely to enjoy a perceived status and credibility of being regulated by the scheme. Any mis-perception by health entities that not being regulated by the National Law "disqualifies" the other health practitioner groups from particular benefits needs to be addressed through information which explains that the scheme deals with the professions that have higher safety risks.

Only those that have a scientific basis to their practice should be included in the scheme.

Much work has already been devoted to developing a National Code of Conduct for the health care workers to be governed by State and Territory health care complaints entities. This should

be implemented as planned. If there is some concern by governments about the cost of administering the code of conduct mechanism, it could consider a system of health care workers paying an application fee to be "recognised" as a practitioner who practises according to the code of conduct, which would give them a market advantage.