AUSTRALIAN COUNCIL OF PHYSIOTHERAPY REGULATING AUTHORITIES LIMITED

SUBMISSION TO THE PRODUCTIVITY COMMISSION STUDY IN RESPONSE TO THE POSITION PAPER RELATED TO THE HEALTH WORKFORCE STUDY

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INTRODUCTION

The Australian Council of Physiotherapy Regulating Authorities (ACOPRA) commends the Productivity Commission on the preparation of a comprehensive Position Paper. Generally speaking, many of the proposals within the Position Paper offer realistic and positive change to better address the healthcare needs of all Australians in the next decade and beyond.

The role of ACOPRA is to advise, investigate, accredit and make recommendations relating to the registration, standards of education, competency and practice of the physiotherapy profession. ACOPRA's membership includes each of the eight State and Territory Physiotherapists Registration Boards, the Australian Physiotherapy Association and the Schools of Physiotherapy in Australia. ACOPRA's mission is to lead the national agenda for the assurance of high standards in physiotherapy for the Australian community. ACOPRA and its members are committed to improving quality of health care and enhancing access to health care by all Australians.

ACOPRA is pleased to have the opportunity to contribute to the continuing development of the Commission's work in this important study. ACOPRA has focused its comments within this submission to the chapters of the Position Paper directly related to the organisation's areas of responsibility, specifically Health Workforce Education and Training, Accreditation and Registration.

GENERAL COMMENTS

The importance of ensuring safe and effective health care for all Australians

The Australian community deserves a high standard of health care delivered by the professionals who are best placed to provide safe and effective care. However, ACOPRA remains concerned that, despite a clear intent by the Commission to move to a more responsive and adaptable system of health care delivery, much of the content of the Position Paper contains references to traditional medical models of health care with an inherent "doctor-centric" focus.

ACOPRA contends that safe and effective health care is best provided by a team approach based on evidence of outcomes of various interventions and not by a system that is predicated upon the doctor as the "gatekeeper" of decision making regarding appropriate care and referral to other professionals.

ACOPRA contends that unless there is a clear shift to models that focus on, at a macro level, the needs of the community and, at a micro level, the needs of the health care consumer, many of the current inefficiencies and problems within the health workforce will not be addressed.

Incorrect, inaccurate and incomplete information within the Position Paper

ACOPRA is pleased to have the opportunity to highlight incorrect, inaccurate and incomplete information that has been reproduced in the Position Paper. Specifically, on page 93, Box 6.1 states "Using hours is a fundamental yardstick, e.g. in Radiography and Physiotherapy, is inappropriate in a work environment where processes and practices have changed radically in the last 20 years, and which is also fundamentally inhospitable to the trainee. (Monash University, Faculty of Medicine, Nursing and Health Sciences, Sub.89, p. 6-7).

Contrary to the Monash submission and the statements made by Professor Stephen Duckett at the Roundtable meeting in Melbourne on October 27th 2005, the accreditation processes for entry level physiotherapy education programs in Australia have never used hours as a yardstick (Attachment 1). As indicated in Attachment 2 *Standards for Accreditation of Physiotherapy Programs at the Level of Higher Education Awards*, the accreditation process is based on outcomes and the principles upon which it is based include the encouragement of innovation in achieving educational objectives.

ACOPRA is concerned that there appears to be a strong medical bias in the Commission's understanding of many of the issues discussed in the Position Paper. This bias has, in some sections, led the Commission to conclusions and proposals based on limited information. For example, Chapter 5 does not consider the fact that postgraduate clinical training for physiotherapists is entirely self-funded, despite physiotherapy expertise being

essential in many areas including the management of major surgery, rehabilitation following stroke, and the management of complex musculoskeletal injury.

In discussions at the Roundtable Meeting in Canberra on 1st November 2005, the accreditation model of the Australian Medical Council was commended by the Commissioners, with a suggestion being made that this model should form the basis for a national model of accreditation There was no acknowledgement of the outcomes focused accreditation model implemented by ACOPRA for physiotherapy education programs as referred to in its initial submission. The ACOPRA accreditation process extends beyond that of the AMC in terms of its focus on outcomes. Of particular note is that the ACOPRA accreditation process includes evaluation of first year graduates and their employers using standard surveys to assess whether the university program is producing graduates who can fulfil generic expectations such as communication and problem solving as well as practise safely and effectively as a physiotherapist in the current Australian health care settings. ACOPRA would be pleased to have the opportunity to contribute to the development of nationally consistent principles for the accreditation of health education programs in Australia.

Health professions are dynamic and responsive

ACOPRA is concerned that several of the Commission's comments within the Position Paper suggest that the Commissioners may have the impression that many health professions are not dynamic or responsive when in fact, the opposite is true. For example, ACOPRA is actively engaged with the registration boards in developing guidelines for regulation of extended scope practices and physiotherapy assistants - this work is well advanced. In April 2005, ACOPRA hosted the second annual national meeting of health professions assessing authorities in Canberra to share information regarding the assessment of overseas trained health professionals. In 2006, the accreditation of entry level physiotherapy programs will also be discussed by the relevant agencies.

Rather than a silo-based health workforce, there is in fact a high level of informal communication and information sharing between professional bodies and teams of professionals. ACOPRA contends that the development and promotion of core principles

in the areas of health education and training, accreditation and registration would be better achieved through the formalisation and expansion of existing communication and information sharing, rather than the creation of new national agencies.

SPECIFIC COMMENTS

Chapter 5: Health workforce education and training

The quality and relevance of the education and training provided

The physiotherapy education system is very responsive to the workforce needs through active engagement with the employers of physiotherapists. ACOPRA has assisted in facilitating collaboration between academics and clinicians to facilitate the preparation of graduates who are "work ready".

The accreditation process implemented by ACOPRA includes evaluation of the graduates' suitability for the workforce through surveys of graduates and their employers at the end of the first year of employment. These outcome measurements inform each university regarding the quality and relevance of the education provided during the entry level physiotherapy program and are powerful tools for ensuring graduates continue to be suitable for work in a dynamic health care environment.

The duration of education and training

Under current models of education, physiotherapists graduate as generalist practitioners with clearly demonstrated capacity to move into more specialist areas. There are already programs that prepare generic health science graduates and there is no evidence to suggest that these people enrol in more advanced or specialized areas.

ACOPRA does not support the preparation of multi-skilled health workers through the development of a common degree program on the grounds that current evidence suggests this model does not adequately prepare graduates who are job-ready upon completion of their training.

ACOPRA supports interprofessional learning models, as well as core learning within health education programs, where the mix of students appropriately reflects the needs of later stages of the students' programs, the intellectual capacity of students and the needs of the health system.

ACOPRA is supportive of increased course length – this is already achieved through the graduate entry Masters programs that produce work ready physiotherapists who have undertaken a relevant three or four year Bachelor degree followed by a two (calendar) year Master of Physiotherapy degree. Unfortunately current funding models do not provide Commonwealth Government supported places for students undertaking Masters entry-level programs despite the fact that these programs are normally of shorter duration and provide an opportunity for a more rapid response to workforce shortages.

Alternative models of health workforce preparation

While the "skills escalator model" and recognition of prior learning have some merits in being able to provide a more adaptive workforce, ACOPRA suggests that it is important that these approaches do not simply focus on competencies in terms of a knowledge and skill set, but incorporate the principles of achievement of clinical competence and the clear capacity for making informed and appropriate clinical decisions (Attachment 3).

The repeated references to 'university-based training of health workers' denies some of the important elements of university education. Universities are clearly more than workforce training institutions – a central role of universities is to

undertake research to provide evidence for the most cost effective and efficient health practices and to imbue graduates with the capacity to continue to learn and incorporate new developments into their own practice.

ACOPRA cautions the Commission against a model that focuses on "training" of the health workforce as this runs the risk of reliance upon a health economist solution to developing an efficient workforce. It is questionable how effective this type of model can be in the longer term as key elements of the make up of the health workforce would be diluted, if not extinguished.

ACOPRA contends that it is important to develop educational models that adequately provide for the duration of education and training that is required to develop expert clinicians who can meet the increased demands of providing quality clinical services today and in the future.

ACOPRA supports the development of educational models that allow for multiple exit points so that students could obtain a qualification recognising a more limited skill set and the ability to practice under supervision of staff who have completed more extensive training. The analogy of a train line with a major terminus and multiple stations along the line where students can get on and off might be a better analogy than the "escalator" model.

Lack of access to clinical training

ACOPRA is concerned that there appears to be a continued lack of understanding by the Commission of the crisis situation affecting clinical education. This is not a short term or medical-only problem - the situation will continue as a critical problem in physiotherapy unless there is funding made available to increase the numbers of clinical educators. The critical situation in clinical education may well result in a lack or preparedness of some physiotherapy graduates for the full scope

of entry-level expectations of the workplace. This will have the effect of shifting an additional educational burden onto the clinicians – some would argue this is already happening.

ACOPRA supports initiatives to increase access to clinical placements within the private sector. There is great potential for these initiatives; however funding is required to support the introduction of placements within the private sector. It is imperative that private health insurance funds, Workcover insurers, motor accident insurance authorities and other agencies that fund health care services in the private sector agree to pay for services provided by a student under the supervision of a physiotherapist. ACOPRA recommends that the Commission includes a reference in its final report to the need for negotiation with these agencies to ensure billing arrangements are changed to permit student treatment under supervision to be invoiced through these agencies in the same way as services provided by fully registered physiotherapists.

ACOPRA fully supports the statement in the Position Paper on page 65, Box 5.2, *There is a huge amount of pressure placed on public hospital physiotherapy departments to provide undergraduates with the experience they need to be job ready. The system largely functions on the good will of clinicians and is unsustainable.*

The issue of sustainability is also highlighted in a recent report of a project funded by the Australian Universities Teaching Committee (now the Carrick Institute) entitled *Learning Outcomes and Curriculum Development in Australian Physiotherapy Education* – a high level of concern exists regarding the ability of the universities and professional clinical colleagues to continue to provide the level of clinical education required to produce safe and effective graduates. The recommendations of this project highlight the urgent need for the Federal Government to review the Commonwealth Course Contribution Schedule and reclassify physiotherapy as a clinically based medical science. Without the additional funding that this

reclassification would provide, it will be impossible to maintain clinical education programs in the future.

ACOPRA reinforces this recommendation and urges the Commissioners to familiarise themselves with the outcomes of this important and highly relevant project. The executive summary of the report is available at www.carrickinstitute.edu.au/carrick/go/pid/65.

Course funding relativities

The current Commonwealth Course Contribution Schedule allocates $15,000 per year per student place for medicine, $9,700 for nursing, and $7000 for allied health. There is no acknowledgement that the biomedical sciences required for physiotherapy are on a par with those for medicine and in some universities are co-taught. Furthermore, there is an explicit clinical training component in the Government's contribution to medical and nursing courses, but none for allied health. As a direct consequence, the universities conducting allied health education programs are unable to meet the substantial costs of providing clinical education.

There is a clear need to provide Government support for Postgraduate Education and Training in the allied health disciplines. Currently all physiotherapy postgraduate training delivered by the universities is provided on a 100% user pays basis – that is, postgraduate students pay full fees. The impost of these fees has resulted in a significant reduction in the number of Australian physiotherapists completing professional Masters programs since 1997. Ultimately this is likely to have a negative impact on the specialist physiotherapy care provided to the Australian community. Already there are serious workforce shortages both in metropolitan and rural areas of physiotherapists with expertise in paediatrics and cardiorespiratory physiotherapy.

A potential solution may be supported by section 73-5(1) of the Higher Education Support Act 2005 (Cth). This section provides all individuals with a Student Learning Entitlement equivalent to 7 years of study. While it is not specifically excluded in the Higher Education Support Act 2005 (Cth), the Department of Education, Science and Training (DEST) does not permit students to use this learning entitlement for postgraduate study.

ACOPRA strongly encourages the Commission to recommend that students in health related courses be permitted to use part of their learning entitlement for postgraduate study since a more highly trained workforce will clearly be of benefit to the broader community. Such a change would also permit more students to enter accelerated graduate entry masters programs with the benefit of being able to provide a more rapid response to workforce needs in particular health disciplines.

Comments in relation to draft proposal 5.1

ACOPRA acknowledges the need to have an education system that is responsive to the needs of the health workforce and health system, and supports a much stronger role for the Department of Health and Ageing (DOHA), State Government health departments and representatives from the private health sector in determining the number of student places in health disciplines in Australian universities.

ACOPRA does not support the proposal to transfer allocation of the quantum of funding to DOHA and strongly recommends that DEST should retain control of funding distribution and student enrolments. A primary consideration is that despite the involvement of DOHA in the allocation of medical student places, the Committee of Deans of Australian Medical Schools (CDAMS) submission reveals that this model has caused difficulties and produced "chaotic effects".

A secondary consideration is the fact that DOHA has also been responsible for the allocation of funding to Rural Clinical Schools. Outcomes in this area suggest that it is not as the Commission suggests, merely a perception (p. 72) but a reality that DOHA would be likely to focus almost exclusively on medicine [and may be forced to focus on nursing by union activity] and that interprofessional activities would not be supported.

Comments in relation to draft proposal 5.2

ACOPRA supports the development of alternative and innovative approaches to health workforce education and training, particularly in the area of clinical education.

ACOPRA does not support the establishment of a national health workforce education and training council. ACOPRA considers that the effectiveness and efficiency of a stand-alone education and training council is likely to be limited.

As an alternative and a more holistic solution, ACOPRA recommends the development of a single agency for health workforce improvement, education and training. This recommendation is based on the amalgamation of the health workforce improvement agency proposed by the Commission in draft proposal 4.1 and that proposed in draft proposal 5.2. Such an agency could have clear oversight of data collection and provision of advice regarding innovative approaches to issues such as clinical education models, including the use of standardised and simulated patients.

ACOPRA would seek assurance that such an agency would have a balanced membership where 'allied health' is not considered a single entity but that individual professions are represented, and that appropriate expertise could be

coopted to assist in providing independent and transparent evaluation of innovative approaches.

Comments in relation to draft proposal 5.3

ACOPRA strongly supports draft proposal 5.3 as it is consistent with ACOPRA's position regarding the primacy of a comprehensive physiotherapy clinical education program (Attachment 4). ACOPRA supports the greater use of explicit payments to those providing infrastructure support for clinical training. Explicit funding should be allocated to universities to manage the allocation to their clinical education providers – in particular, to support additional staff members who have a primary responsibility for supervision of clinical education. This explicit funding is essential to break the current nexus between service delivery and clinical education. DEST should specifically ensure that universities are prevented from using this clinical funding for other purposes eg to cover administrative costs.

It is this nexus that is the primary source of workplace pressure and stress for many physiotherapists in the public sector who are expected to manage both a full patient load and teach students within a normal working week. ACOPRA acknowledges and supports the continuing important role of some *pro bono* contributions to clinical education but stresses that a model that relies significantly on such contributions is not sustainable.

Chapter 6: Accreditation

ACOPRA contests the suggestion that accreditation influences matters such as job design and division of work between professions. These matters are largely

determined by the health system itself, and not by accreditation bodies such as ACOPRA.

ACOPRA acknowledges the need for consistency of approach across various accreditation agencies and, within this, the need to adopt best practice approaches to accreditation and quality control. ACOPRA contends that the retention of profession specific mechanisms to implement accreditation are essential to maintaining the fabric of health professions themselves. In turn, it is the rich fabric of the health professions in Australia that creates a world-class system in terms of safety and quality of care.

Comments in relation to draft proposal 6.1

ACOPRA supports a national across-profession approach to accreditation as a sound mechanism to develop policy and set standards to achieve consistency and best practice. ACOPRA contends that a single national accreditation agency such as that proposed by the Commission would be large and unwieldy with the potential to develop a significant bureaucracy and the potential to make accreditation processes slower.

Instead, ACOPRA supports the establishment of a national body to oversight the national accreditation bodies in the specific disciplines. ACOPRA suggests the national accreditation advisory agency would comprise up to ten members and include representatives from the five largest health professions - doctors, nurses, pharmacists, dentists and physiotherapists. Such a body could establish guidelines for accreditation processes and promote consistency of approaches and development of best practices by the various accreditation bodies. It will be vital that professional expertise is structured into the national body, with specific additional expertise called upon as issues arise.

ACOPRA has implemented, and continues to implement, a consistent national approach to accreditation. ACOPRA is committed to continuous quality improvement of its outcomes-based system of accreditation, most recently evidenced by a project to review its current guide and redevelop a best practice guide to development of an application for accreditation of an entry level physiotherapy program (this project is in progress). ACOPRA contends that implementation of accreditation processes in accordance with a consistent national approach should be the responsibility of the professions. Each profession would furnish a confidential final report for each accreditation activity to the national accreditation advisory agency.

ACOPRA supports the mandatory development of uniform national standards upon which professional registration would be based but contends that these should be profession-specific standards and development should remain the responsibility of the profession, in consultation with the national accreditation advisory agency.

Comments in relation to draft proposal 6.2

ACOPRA recommends that the national accreditation advisory agency should develop guidelines for a nationally consistent approach to the assessment of overseas trained health professionals and have oversight of the mandatory development of profession-specific processes that comply with the guidelines.

Chapter 7: Registration

ACOPRA is committed to the promotion of a nationally consistent approach to the registration of physiotherapists in Australia that assures high standards of physiotherapy for the Australia community. Evidence of this commitment is the development and implementation of a model to enhance the accountability of the

profession and at the same time enhance the mobility of physiotherapists within Australia (Attachment 5), as well as a model to promote a consistent national approach to the conditions and criteria applied by registration boards when considering various forms of limited registration for overseas trained physiotherapists (Attachment 6).

The limited registration model enables overseas trained physiotherapists to work for up to one year under the supervision of a fully registered physiotherapist. ACOPRA is very aware of physiotherapy workforce shortages but, at the same time, has a responsibility to ensure overseas trained physiotherapists have the same level of applied knowledge and understanding and problem solving skills expected at graduation in Australia. This model balances the need to formally assess overseas trained physiotherapists prior to approving full registration with the need to assist overseas trained physiotherapists to fill vacancies in Australia whilst they are on a working holiday or completing the skills assessment process.

ACOPRA has recently developed discussion papers to facilitate a nationally consistent approach to the regulation of physiotherapy assistants and the regulation of extended scope practices.

As previously mentioned, ACOPRA's membership includes each of the eight State and Territory Physiotherapists Registration Boards, the Australian Physiotherapy Association and the Schools of Physiotherapy in Australia. ACOPRA contends that its broad membership and record of current and recent activities provide strong evidence of that it is better placed than the proposed national accreditation agency to promote a nationally consistent approach to regulation of physiotherapy in Australia.

Comments in relation to draft proposal 7.1

ACOPRA supports the case for establishing uniform standards between States and Territories but contends that these should be developed by the Registration Boards and State and Territory Governments and not by the accreditation agency.

Comments in relation to draft proposal 7.2

ACOPRA is in full agreement that the operation of mutual recognition in relation to the health workforce requires improvement and unequivocally supports this draft proposal. ACOPRA recommends that the Commission expands upon this draft proposal and, in the final report, proposes a model of national registration through a similar model to the regulation of corporations.

Comments in relation to draft proposal 7.3

ACOPRA contends that task delegation is already required within registration acts for physiotherapy as well as other professions and that this proposal, in its current form, is redundant.

As previously mentioned, ACOPRA has recently developed discussion papers related to the regulation of physiotherapy assistants and the regulation of extended scope practices. ACOPRA is well positioned to work with the universities, the profession and the registration boards to promote regulatory models that protect the public and meet the needs of a dynamic and adaptable health workforce.

Whilst a consistent national approach to regulation of extended scope practices will assist in enabling physiotherapists to contribute to a more efficient and cost effective health workforce by providing extended scope services, the true potential

of this contribution will not be realised without changes to the range of health services that can access the Medicare Benefits Schedule (MBS).

ACOPRA contends that in the context of the health workforce, task delegation refers specifically to the designation of tasks by a health professional to a person who is less qualified than the health professional – for example, a physiotherapist may delegate tasks to a physiotherapy assistant. ACOPRA contends that, given this definition, medical practitioners may refer patients for physiotherapy but cannot delegate tasks to physiotherapists in the manner described in Chapter 8 of the Position Paper. ACOPRA recommends that the Commission, in its final report, distinguishes between task delegation and referral of clients between health professionals.

Consolidation of registration boards

ACOPRA contends that a model of consolidation of Registration Boards such as that suggested on p. 114 of the Position Paper is only likely to create bureaucracies and inefficient processes. ACOPRA supports the consolidation of registration administrative arrangements across health professions at a jurisdictional level. ACOPRA contends that monitoring and disciplinary processes are best conducted at the State/Territory and professional levels.

Composition of boards

The Commission quite rightly identifies that to the extent that the current composition of boards is causing concern the immediate solution lies with the States and Territories.

ACOPRA contests the Commission's conclusion that it is not necessarily appropriate for practitioners from the profession in question to comprise a

majority of a board's membership. ACOPRA notes that all state and territory governments have seen fit to enact legislation that provides for a majority membership of physiotherapists on registration boards. ACOPRA supports the inclusion of community members on all registration boards, and notes that current legislation provides for this in several states and territories.

ACOPRA contends that it is essential that practitioners from the profession be members of any board or subset of a board when dealing with issues related to that profession, particularly in relation to disciplinary investigations and enquiries.

ACOPRA supports a requirement for registration boards to have:

- clear specification of roles and responsibilities of members;
- robust accountability mechanisms;
- an independent chair; and
- appointment of members in their own right, rather than as representatives of particular organisations, via transparent appointment processes.

Letters to the Editor

ACOPRA does not have a requirement for 1000 hours of supervised clinical experience in entry level physiotherapy programs

I am writing to draw attention to erroneous information included in the Editorial *Is education immune from evidence-based scrutiny?* by Chipchase and colleagues, published in the last issue of the *Australian Journal of Physiotherapy*.

In this Editorial, Chipchase et al make the following statements regarding ACOPRA.

> An example of the lack of evidence base for physiotherapy curriculum is the requirement by the Australian Council of Physiotherapy Regulating Authorities (ACOPRA), albeit not enshrined in policy, that all Australian entry level physiotherapy programs provide 1000 hours of supervised clinical experience. This requirement is based on opinion and intuition rather than credible research … And what of the recommended 1000 clinical hours? Is this really the indisputable benchmark for achieving clinical competency? (p. 134).

While the Editorial is timely in many respects, it is very disappointing that the authors were not as diligent as they should have been in their own evidence-based scrutiny when preparing the Editorial, relying upon unsubstantiated opinion rather than the evidence in making these statements.

Nowhere in ACOPRA documentation relevant to accreditation of entry level programs is 1000 hours of supervised clinical experience mentioned. Not in policy; not in the ACOPRA position statement 'The Primacy of a Comprehensive Physiotherapy Clinical Education Program'; not in the two sets of standards which are used to evaluate programs for accreditation (The Australian Physiotherapy Competency Standards and the ACOPRA Standards for the Accreditation of Physiotherapy Programs at the Level of Higher Education Awards), and not in the ACOPRA manuals of procedures and guidelines provided to physiotherapy schools to assist them in their documentation for accreditation.

ACOPRA does not accredit programs on a set number of hours of clinical experience, and nor should it. ACOPRA is far more responsible than the authors would have readers believe. When an ACOPRA accreditation committee evaluates the documentation provided by a university against the two sets of standards referred to previously it is concerned with the quality, comprehensiveness, and depth of the clinical education experience provided by a physiotherapy program for its students. It is also pertinent to mention that these two sets of standards were developed and signed off by the three stakeholders groups which make up ACOPRA — the registration boards, the schools of physiotherapy, and the APA.

It is noteworthy that the same issue of the *Australian Journal of Physiotherapy* in which this Editorial appeared also contained a Letter to the Editor from the President of the WCPT, Sandra Mercer Moore, titled *WCPT no longer requires 1000 hours of clinical experience.* Sandra Mercer Moore's letter explained that WCPT dropped the 1000 clinical hours requirement in 1991.

It is disappointing that the authors of the Editorial were insufficiently diligent in their evidence-based scrutiny in apparently neither checking all readily available ACOPRA accreditation documentation and standards in preparing their article nor, for completeness, seeking from the originator of the '1000 hours mantra', the WCPT, an up to date statement of its position.

ACOPRA exists as a Board comprised of Directors who represent the key stakeholders, namely each state and territory registration board, the schools of physiotherapy group, and the APA. ACOPRA values debate on education but is uncompromising when accuracy is a victim in such a debate.

Ruth Grant
Chair, ACOPRA

Reference

Chipchase L, Dalton M, Williams M and Scutter S (2004): Is education immune from evidence-based scrutiny? *Australian Journal of Physiotherapy* 50: 133–135.

We must seek to understand what constitutes effective entry level clinical education

Thank you for the opportunity to respond to the concerns raised by Emeritus Professor Ruth Grant, Chair of ACOPRA, regarding our Editorial *Is education immune from evidence-based scrutiny?* As Professor Grant has confirmed, ACOPRA does not require that entry level physiotherapy programs provide 1000 hours of supervised clinical practice to their students. We acknowledge that an explicit statement about the amount of clinical education required within entry-level physiotherapy programs is not within ACOPRA documentation. However, the responses and feedback to this Editorial suggest that there is a level of misunderstanding amongst clinicians and academics that 1000 clinical hours is still a requirement for entry level training. The clarification provided by the WCPT and the response by ACOPRA to our Editorial provide timely and accessible statements concerning this issue.

The intent of our Editorial was to promote discussion around the issues facing entry level physiotherapy education in Australia. As we indicated in the Editorial, the time is right to evaluate, promote, and debate so that an educational framework based on credible research evidence can be

developed. The current debate and discussions, related to education, are without doubt very important for our profession. As Professor Grant herself noted in 1995 (p. 344), 'The pursuit of evidence that physiotherapy intervention is effective, is indistinguishable from the pursuit of excellence in physiotherapy in times of constant change and challenge.' The emphasis of our Editorial was to highlight that as a profession we must seek to understand what constitutes effective entry level physiotherapy education, particularly clinical education, at a time when education and health sectors in Australia face considerable change and challenge. We believe these issues are a national priority for the immediate and long term future of our profession.

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References

Chipchase L, Dalton M, Williams M and Scutter S (2004): Is education immune from evidence-based scrutiny? *Australian Journal of Physiotherapy* 50: 133–135.

Grant R (1995): The pursuit of excellence in the face of constant change. *Physiotherapy* 81: 338–344.

STANDARDS FOR ACCREDITATION OF PHYSIOTHERAPY PROGRAMS AT THE LEVEL OF HIGHER EDUCATION AWARDS

In the process of reviewing educational programs for accreditation purposes, it is important that in the application of these standards, the following principles be applied:

- Criteria used in evaluating programs do not intrude upon the diverse and unique character of individual programs/institutions.
- There is recognition that excellent education programs may differ in many respects and that educational objectives may be achieved in a variety of ways.
- Innovation in achieving educational objectives should be encouraged.
- While an accreditation process may review a number of input elements, it will not be prescriptive in terms of precise curriculum details.
- An educational program should address professional issues relevant to the time.
- The process of accreditation should be based on the principle of equity and justice in that profession should be assured that the standards would be interpreted fairly and without bias.

Summary of Standards

Standard 1: The outcomes of the programs through the performance of the graduates

Standard 2: The process of education

Standard 3: The mechanisms employed to ensure quality outcomes

Standard 4: The resources and physical environment

Standard 5: The curriculum

STANDARD 1 – THE OUTCOMES OF PROGRAMS THROUGH THE PERFORMANCE OF THE GRADUATES

1.1 As a general principle, universities must demonstrate that they have a program whose graduates will meet the Australian Physiotherapy Competency Standards (APCS) in all key areas of physiotherapy including musculo-skeletal, neurology, cardiopulmonary and electro physical agents across all ages and from acute to community contexts.

1.2 Evaluative procedures shall be conducted by the educational institution to assess the outcome of its program in terms of the standards of the graduates in preceding years and action should be taken on the basis of that evaluation to continually improve that standard of graduates particularly in relation to the APCS.

STANDARD 2 – THE PROCESS OF EDUCATION

2.1 The program is an entry-level program, preferably a four-year degree program.

2.2 Entry into the program is offered on an assurance of equal opportunity with respect to race, creed, colour, national origin, sex, age, handicap, and socio-economic and marital status.

2.3 The academic pre-requisites and any other specific criteria for entry to the program are clearly stated and are compatible with the requirements of the program.

2.4 Policies, procedures and program information is current and readily available to the students particularly related to the aims and objectives, assessment, progression and requirements for graduation, appeals processes, costs and academic review processes.

2.5 The philosophy and objectives of the program are clearly stated and are consistent with the professional practice of physiotherapy.

2.6 The specific learning objectives and teaching plan is available for each unit of instruction.

2.7 The standard of achievement that is expected is clearly stated to the students, and are related to their professional practice and the APCS.

2.8 The program utilises a range of teaching and learning methods appropriate to the achievement of the objectives (2.6) and the learning style of the students.

2.9 The program utilises a range of assessment methods appropriate to the objectives (2.6) for both formative and summative purposes.

STANDARD 3 – THE MECHANISMS EMPLOYED TO ENSURE QUALITY OUTCOMES

3.1 The program is offered in a recognised tertiary education institution, preferably a university, which is supportive of physiotherapy both as an academic and professional discipline.

3.2 The program has established mechanisms of accountability to the university and to the physiotherapy profession.

3.3 There are clear and comprehensive policies on program development.

3.4 There are clear and comprehensive policies for periodic review of program goals, content, relevance and quality.

3.5 There is a clearly defined organisational structure for the overview of the program.

3.6 There are regular reviews of assessment methods that consider the student load and the emphasis, balance and appropriateness of methods and relevance to the APCS.

3.7 The program administrators utilise a range of evaluative methods to monitor and improve the quality of the education process.

3.8 There is an ongoing program of evaluation of the performance of the academic and clinical staff, which includes the assessment of teaching ability, scholarly activity and administrative competence.

3.9 There is an organisational structure that will provide a career path for staff and an ongoing program of professional development for all staff that is linked to evaluation of performance.

3.10 In the philosophy of the program, there is clear recognition of the relationship between research activities and the content and delivery of the program and that this relationship should be demonstrated by staff and student involvement in research and scholarship related to the physiotherapy profession.

STANDARD 4 – THE RESOURCES AND PHYSICAL ENVIRONMENT

4.1 The program has adequate funding available per student to provide sufficient numbers of staff and resources required to achieve the goals of the program. Academic staff representatives have a major input to the development of the budget and the allocation of financial resources within institutional budget guidelines.

4.2 The academic staff has a sufficient mix of qualifications to successfully conduct the program including a diversity of areas of expertise and a diversity of academic qualifications in physiotherapy, related sciences and curriculum design and development.

4.3 Each academic staff member should have documented expertise in the area of teaching responsibility; demonstrated effectiveness in teaching and evaluation of students; and a record of involvement in scholarly research and professional activities consistent with the philosophy of the program.

4.4 There are a sufficient number and quality of relevant clinical placements and educators available to meet the needs of the program.

4.5 There is clear and accessible description of the academic governance of the program with demonstrated lines of accountability and responsibility.

4.6 There is adequate time available and access to academic and clinical staff for students for consultation on progress and program content.

4.7 There are sufficient quantity and quality of classrooms, laboratories, clinical facilities, offices and space for students, academic and general staff to provide an environment conducive to learning and research.

4.8 The students and staff have access to sufficient equipment, particularly physiotherapeutic and electronic equipment relevant to physiotherapy technology, and consumables to provide the means for effective learning and research.

4.9 The students have ready access to a well-maintained and catalogued library of appropriate media and holdings that are current and sufficient in number and breadth to support the content and needs of the curriculum and to meet the needs of the program.

4.10 The students have ready access to those services that will facilitate their successful completion of the program including student counselling. Educational support including language instruction, health and residential facilities, and financial aid.

4.11 The program has adequate support staff and services to meet the needs of the students and the academic staff.

4.12 There are occupational health and safety policies relating to a safe working environment, sexual harassment and disability.

STANDARD 5 – THE CURRICULUM

5.1 The curriculum is designed in sufficient depth and breadth to ensure that the desired outcomes of the program can be achieved that is the preparation of graduates as competent entry-level physiotherapists who meet the APCS.

5.2 The curriculum is designed to ensure the progressive development of skills and independent thinking, ethical and value analysis, communication, clinical reasoning and decision-making and the understanding of fundamental theories of health, illness and human behaviour.

5.3 The curriculum is developed and regularly reviewed at an institutional level by the academic staff of the program with input from representatives of the profession, the student body and other interested groups.

5.4 The curriculum is structured to include classroom, clinical and research experiences that are carefully sequenced and integrated to ensure effective learning and include:

5.4.1 the sciences basic to physiotherapy including but not limited to anatomical, biomedical, physical, physiological, biomechanical, neurobiological, social and behavioural;

5.4.2 the practice of physiotherapy including but not limited to assessment, interpretation, planning, interventions and measurement of outcome;

5.4.3 research methods and scholarly activities including but not limited to the review and critical analysis of research reports;

5.4.4 aspects of broader professional practice including but not limited to professional ethics and legal responsibilities, administration, education, consultation and collaborative health care provision.

5.5 The content of the curriculum and the organisation of the learning experiences foster a commitment to continuing professional growth including learning through self-directed, independent study.

5.6 The content of the curriculum addresses clinical practice and professional issues relevant to the time.

5.7 The clinical education is organised in a sequential and integrated manner to ensure the timely and progressive exposure to students to a variety of patients with problems of increasing complexity.

5.8 The supervised clinical practice experience has sufficient breadth, depth and comprehensive coverage to ensure that the objectives of the program are met, and that the students have the opportunity to integrate theoretical concept into clinical practice. Sufficient periods of supervised clinical practice are scheduled following theoretical and practical education so that students are able to understand the total needs of their patient clients and offer a holistic program, and appreciate the needs of patients with complex clinical conditions. Students perform professional responsibilities under appropriate levels of supervision; have opportunities to observe professional role modelling and to practice with timely and constructive feedback their professional skills and clinical reasoning.

5.9 In the clinical environment, there are specific procedures established for communication between the clinical educators and the students for both issues of patient care and for teaching and learning.

5.10 The academic and clinical staff determine that the students are competent and safe to function in the clinical setting according to the APCS, using both formative and summative assessment. A final comprehensive evaluation of students' clinical competence should be included.

5.11 There are specific procedures established for communication on professional, curriculum and administrative matters between the clinical educators and the academic staff.

5.12 There are written agreements between the university and the clinical teaching centres describing the expectations and responsibilities of both parties.

Assessing health professionals

Jim Crossley,[1] *Gerry Humphris*[2] *& Brian Jolly*[3]

Background Good professional regulation depends on high quality procedures for assessing professional performance. Professional assessment can also have a powerful educational impact by providing transparent performance criteria and returning structured formative feedback.

Aim This paper sets out to define some of the fundamental principles of good assessment design.

Conclusions It is essential to clarify the purpose of the assessment in question because this drives every aspect of its design. The intended focus for the assessment should be defined as specifically as possible. The scope of situations over which the result is intended to generalize should be established. Blueprinting may help the test designer to select a representative sample of practice across all the relevant aspects of performance and may also be used to inform the selection of appropriate assessment methods. An appropriately designed pilot study enables the test designer to evaluate feasibility, acceptability, validity (with respect to the intended focus) and reliability (with respect to the intended scope of generalization).

Keywords Professional competence/*standards; reproducibility of results; *educational measurement; England.

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Introduction

Assessment is important

Good professional regulation depends on good assessment

In the UK, recent, highly publicized failures of medical performance and conduct have threatened public confidence in the medical profession[1] and in professional self-regulation.[2] The General Medical Council (GMC) has responded by making dramatic changes to the process of self-regulation.[3,4] Specific developments include rigorous procedures to investigate apparent under-performance[5,6] and revalidation.[7] At the same time, the government has called for better measures of the quality of clinical practice.[8] Similar developments are taking place all over the world and throughout the health professions. All these initiatives stand or fall on validated methods to evaluate professional competence and performance.

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Transparent performance criteria and formative feedback help 'testing' to improve its object

There are, however, more positive educational reasons for welcoming the challenges posed by assessment of professional activity. The verb 'to test' carries two distinct meanings. One is to *discover the worth* of something by trial; the end result is more information about the object of testing. The other is to *improve the quality* of something by trial; as when metal is tested in a flame, the process results in a changed and improved test object. The educational value of assessment is easily underestimated. The nature and content of assessment strongly influences the learning strategies that students adopt because most learners are adept at spotting and meeting the requirements of an assessment.[9,10] Moreover, the profile of strengths and weaknesses that a well-designed assessment can reflect back to the learner is a very powerful educational tool, showing where areas of strength and weakness lie and giving a focus to further learning.[11]

This paper represents part of a series introducing a number of new and old methods for assessing competence and performance. The present article describes some of the important elements of general assessment methodology. In setting the context for the articles that follow, we draw attention to some fundamental principles of assessment design, areas of recent development and areas of potential controversy or confusion.

Key learning points

The purpose of an assessment process should drive every aspect of its design.

Deciding exactly what an assessment should measure is a deceptively difficult task.

Make explicit the range of situations that the result is supposed to represent.

Blueprinting can aid the selection of an efficient sample of practice across the key aspects of performance and may inform the selection of appropriate assessment methods.

Test design is a compromise between measurement rigour and practicality.

Evaluate feasibility, acceptability, reliability, validity and, where possible, educational impact in a pilot study.

Concepts and controversies in assessment

Define a focus, but be aware of problems

The common-sense assertion 'If you don't know where you're going, you probably ain't going to get there' is as true of assessment as it is of navigation. A clear definition of the purpose and focus of an assessment should drive the selection of appropriate methods and samples of behaviour.[12] Unless the purpose and focus are made explicit, it is likely that inappropriate methods will be chosen and that these will measure what is easily measured rather than what the designer intends to measure.[13] Only a short time ago, it was common practice to judge the competence of doctors for clinical practice exclusively on the evidence of written papers. The implicit assumption is that 'knowledge' serves as a suitable proxy for the integrated functioning of the many attributes necessary to solve the problems and complete the tasks required in clinical practice. When made explicit, this assumption is clearly tenuous. Many of the assessment methods described in this series have been developed in response to this challenge.

Even now, it is no simple matter to define the focus of an assessment. The domain of professional activity is broad and has no obvious planes of cleavage. Taxonomy must be applied, and there are many different ways to divide the elements of practice of a given health professional. Consider the following aspects of performance:

- empathy and sensitivity;
- communication skills, and
- conceptual thinking.[14]

Compare them with:

- taking an adequate history of chest pain;
- performing an ECG, and
- educating a patient on the use of anti-anginal medication.[15]

Each set reflects a valid attempt to divide up professional activity, but the two attempts have produced entirely different and overlapping sets of categories. The former are based around 'relatively stable attributes of health care providers' and represent 'structural' elements, whereas the latter are based around tasks and problems and represent 'process' elements.[16] Confusingly, their authors describe both types of element as competencies. Thus it appears that competencies can be viewed in two ways: as attributes or as tasks.

Three well-recognized frameworks can assist in defining a clear and reproducible focus for assessment. First, Miller's pyramid divides up the domains of cognition and behaviour (Fig. 1).[17] We now know that the demonstration of competence (*shows how*) does not predict day-to-day performance (*does*).[18] Next, Bloom's taxonomy[19] has been transmuted into the widely accepted framework 'knowledge', 'skills' and 'attitudes'. This helpful subdivision of Miller's cognitive domain can guide the selection of an appropriate assessment method; knowledge tests are unlikely adequately to examine skills or attitudes. Finally, Donabedian suggests that assessment may be focused at the level of 'structure', 'process' or 'outcome'.[16]

Deciding *how* to categorize professional activity is not the same thing as actually selecting the important elements of professional activity for a particular assessment. Typically, the selection is based on expert opinion, consensus amongst stakeholders, task analysis, or an analysis of critical incidents. The GMC's framework *Good Medical Practice* is an example of such a selection based on expert opinion.[20] Systematically defining the critical elements in the practice of health professionals in various specialities and at various stages of professional development is one of the major tasks facing assessors today; it is fundamental to good assessment.

Use a blueprint to select methods and samples

The activity of health care professionals is extremely complex and an assessment process must focus on many elements of performance if it is to provide a valid

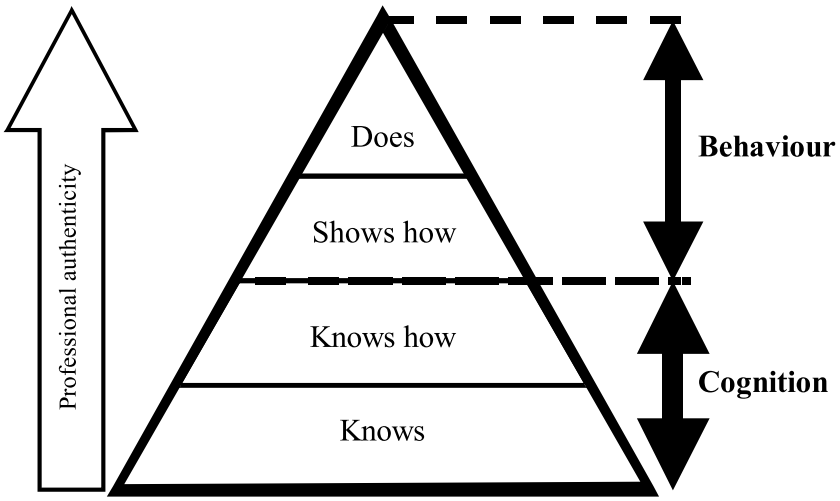

Figure 1 After Miller GE. The assessment of clinical skills/competence/performance.

reflection of any part of the professional role. At the same time, best reliability is achieved by using multiple methods of assessment. The resulting, potentially complex, assessment process can be co-ordinated by using a blueprint. A blueprint specifies all the elements of performance relevant to the assessment so that appropriate samples of activity and corresponding methods can be selected according to their relative importance to the overall assessment process.[12] In blueprinting, the essential elements of the assessment are arranged on a multidimensional grid. Typically in the clinical context, clinical problems are set out along one dimension and the clinical tasks required to address each problem are set out along another dimension. A third dimension might be used to identify different clinical settings or types of patient across which it is important to sample performance. A sample of practice representing a good selection from each dimension can be identified within this matrix.

Although there are many assessment tools available, each of them uses information from a limited number of methodologies, such as paper and pencil or computer tests, face-to-face tests, direct observation of real or 'controlled conditions' behaviour, reported observation by non-judges (peers, nurses, patients, etc.), audio or video-recorded behaviour, examining material evidence (notes, letters, etc.), or examining proxy statistics (mortality, complaints, awards, etc.). An appropriate methodology can be selected for each sample-point within the blueprint.

Select standards and present results according to purpose

Assessment can serve many purposes. For example, it can ensure a minimum level of competence for registration, rank competitively, provide formative feedback or evaluate teachers or courses. Each purpose requires different standards and a different presentation of the results. For registration, it is appropriate that standards are set with reference to fixed and stable criteria (criterion or absolute-referenced), and a simple pass/fail result is all that is necessary. For competitive ranking, each assessee's results set the standard for those of others. Formative feedback requires not a single result summing up performance in all areas, but a profile of the strengths and weaknesses pertaining to each area.[21] The results of individual students need not be specified in teacher or course evaluations; instead, groups of students may be treated as cohorts. It is, of course, perfectly possible for a single assessment to serve several of these purposes simultaneously. A summative assessment for registration can also produce rich, profiled feedback for the assessee, but there may have to be compromises in the design of the assessment.

Evaluate reliability over a specified range of contexts

Reliability is the degree to which a result reflects all possible measurements of the same construct (aspect of competence/performance).[22] At its simplest level, evaluating reliability requires a clear statement of the range of circumstances that the result is supposed to represent. My assessment of the communication skills of a particular doctor with a particular patient today may be very reproducible, but it does not necessarily reflect the assessment of any observer, or the communication skills of that doctor with any patient or on any day. We usually assume or intend a wide generalization for the results of professional assessment.

Strategies are available to combat the main threats to reliability. The subjectivity of observers may be reduced

by training and by the definition of clear performance criteria. However, it is difficult to reduce complex competences to a checklist of observable processes and, counter-intuitively, observers may produce more reliable ratings by using global rating scales than by using checklists.[23] Professional behaviour is also highly dependent on the nature and details of the problem in question. The same competency may be demonstrated better or worse in different settings or different test observations (e.g., with different cases). This phenomenon is known as case-specificity.[24] The simplest solution to observer subjectivity and case-specificity is to include more observers and more cases or problems in the final assessment, but this increases cost.

The traditional approach to evaluating reliability involves conducting a number of experiments to evaluate the size of each of the potential sources of error (e.g., observer, patient, occasion). A more sophisticated approach is described in a later paper on generalizability theory.[25]

Evaluating validity with reference to the focus and purpose

Validity is the degree to which a result reflects the construct it is supposed to measure.[22] An unreliable result cannot be valid because, whatever it measures, it does so inconsistently. However, a reliable result may also be invalid: it may measure an unintended construct.

As a bare minimum, an assessment process or tool must firstly look as though it measures what is intended (face validity) and must include the relevant performance criteria and samples of behaviour (content validity). Next, its reliability should be established. Finally, validity should be tested empirically. Ideally, the assessment should be compared with a gold standard of measurement, but such a thing rarely exists in behavioural assessment. In its absence, the results of several measures of the same element of performance are compared in order to test 'criterion validity'. Statistically, the more measures there are in agreement, and the more closely they agree, the more likely it is that they do actually measure what they claim to. An alternative approach, 'construct validation', is a back-to-front hypothesis test. The investigator states a reasonable hypothesis about the construct to be measured and evaluates the validity of the measure by its ability to confirm the hypothesis. For example, surgical skill (the construct) might be expected to improve with years of training (the hypothesis). Thus a measure of surgical skill is more likely to be valid if it shows progressively better results in groups of surgeons with more training.

All of these validity judgements depend on a clear statement of the focus of assessment. Validity tests commonly fail because they compare assessments that focus on different competences or different aspects of the same competence. Defining an explicit focus will prevent a competence test being mistaken for a performance test, or a knowledge test being mistaken for a skill test.

Recognize and respect the necessary balance between rigour and feasibility

All assessments must balance rigour (reliability and validity) against practicality (feasibility, cost and acceptability).[26] Validity and reliability are maximized by using multiple test forms. Reliability is maximized by testing with as many observers and cases or situations as possible – ideally *all* possible observers and cases. Clearly, however, such strategies are costly and may become unfeasible and unacceptable. Rigour may be paramount in some highly staked judgements such as registration, but practicality may be equally important for iterative in-training assessments. These considerations should drive the final test design.

Summary

1 Clarify the purpose of assessment.
2 Specify a focus. The use of Miller's pyramid, Blooms taxonomy and Donabedian's classification should aid specificity. Blueprinting can co-ordinate sampling across several aspects of performance. The selection should relate to the overall purpose of the assessment.
3 Specify the intended scope of generalization with particular regard to observers, occasions, and cases/samples of practice. In most instances, the result is interpreted as if it represents the whole 'universe' of generalization, but this requires critical evaluation.
4 Select methods and tools that are 'face valid' for the defined focus. Select cases/samples of practice and observers to provide the necessary scope of generalization. The breadth of these samples will represent a compromise determined by the purpose of the assessment; a bigger sample better represents the 'universe' of possible circumstances but increases cost and complexity.
5 Pilot test the assessment. Evaluate reliability with respect to the intended scope of generalization. Evaluate validity with respect to the intended focus and purpose.

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AUSTRALIAN COUNCIL OF PHYSIOTHERAPY REGULATING AUTHORITIES LIMITED
Incorporating The Australian Examining Committee for Overseas Physiotherapists

ACOPRA POSITION STATEMENT

THE PRIMACY OF A COMPREHENSIVE PHYSIOTHERAPY CLINICAL EDUCATION PROGRAM

SUMMARY

Institutions submitting a physiotherapy education program for accreditation by ACOPRA must demonstrate that students within such a program (and graduating from it) have access to a comprehensive clinical education experience where clinical placements provide adequate breadth and depth. Such adequacy of breadth and depth of supervised clinical practice is critical if an institution is to demonstrate that it has a program the graduates of which will meet the two sets of Standards upon which ACOPRA Accreditation is based. These Standards are the *Standards for Accreditation of Physiotherapy Programs at the level of Higher Education Awards* and the *Australian Physiotherapy Competency Standards.*

Since 1997 when accreditation of physiotherapy education programs commenced there has been a 300% increase in the number of programs offered. As of August 2005 there are 18 programs leading to an award in physiotherapy compared with six in 1997, with at least two more "in the pipeline". This burgeoning of physiotherapy programs has not been matched by a growth in the health sector, adequate access to which is pivotal to the preparation of graduates for beginning practice in all key areas of physiotherapy, across all ages and from acute to community contexts.

Institutions submitting a program for accreditation must be able to successfully demonstrate that the students in such a program (and graduates from it) will have access to supervised clinical practice of adequate depth and breadth to meet the Standards upon which accreditation is based. Whilst this applies to all institutions, it is particularly significant for those institutions offering a new physiotherapy education program. Inability to successfully demonstrate that a program will meet the Accreditation Standards will mean that graduates emerge from a program that cannot be accredited or one where accreditation is significantly delayed, with repercussions for graduates in the workplace.

Before planning to offer a new program in physiotherapy, institutions are urged to ensure that adequate clinical placement experience is available for the students who will enter the program. Furthermore, institutions should ensure that they are in a position to appoint early in the process, academic staff experienced in each of the key areas of physiotherapy practice.

PREAMBLE

Accreditation of physiotherapy education programs in Australia provides a mechanism that ensures quality education, allows enhancement of physiotherapy education programs, provides a process for recognition of physiotherapy qualifications conferred upon completion of physiotherapy education programs for physiotherapy registration in Australia, protects the standing of Australian higher education awards, assures the educational community and the general public that the programs accredited are appropriate to the award conferred, ensure compatibility of tertiary awards in physiotherapy and their national and international recognition, and serves to protect the public from incompetent practitioners.

The process for accreditation of physiotherapy education programs in Australia was introduced in 1997. Earlier, in the 1980s, physiotherapist registration boards were instrumental in conjunction with schools of physiotherapy and the professional association, in establishing a working party to develop physiotherapy competency standards. The intent being that once developed these standards could be used as a resource for an accreditation process. The Australian Physiotherapy Competency Standards (APCS) were finalised in 1994 and were updated in 2002. During 2005, ACOPRA is undertaking a major review of the APCS.

THE ROLE OF ACOPRA AND THE STANDARDS CENTRAL TO ACCREDITATION

The role of ACOPRA is to evaluate the physiotherapy education program and the capacity of the institution offering the award in physiotherapy to do so according to specified standards. Accordingly, ACOPRA will consider not only the curriculum and the process of education, but also the mechanisms employed to ensure quality outcomes, the resources available and the performance of graduates. Issues relating to student selection and progression, staff expertise and opportunities for development, and secure arrangements for supervised clinical practice will be addressed.

ACOPRA, in carrying out the accreditation process, evaluates submissions from institutions for accreditation of physiotherapy education programs against two Standards and the extent to which the institution and the program comply with these Standards must be demonstrated.

These Standards are the *Standards for Accreditation of Physiotherapy Education Programs at the Level of Higher Education Awards* and the *Australian Physiotherapy Competency Standards. (*For ease of reference they are often referred to as the ACOPRA Standards and the APCS Standards respectively.)

The *Standards for Accreditation of Physiotherapy Education Programs at the Level of Higher Education Awards* are five in all. These are:

- The outcomes of the program through the performance of the graduates
- The process of education
- The mechanisms employed to ensure quality outcomes
- The resources and physical environment
- The curriculum.

Standard 1 relates to the outcomes of programs through the performance of the graduates and contains two elements that are important to reiterate here. Importantly, both elements link these Standards with the second set of Standards, namely the *Australian Physiotherapy Competency Standards (APCS).*

The elements of *Standard 1 - the outcomes of programs through the performance of the graduates* are as follows:

1.1 As a general principle, universities must demonstrate that they have a program whose graduates will meet the APCS in all key areas of physiotherapy including musculoskeletal, neurology, cardiopulmonary and electrophysical agents across all ages and from acute to community contexts.

1.2 Evaluative procedures shall be conducted by the educational institution to assess the outcome of its program in terms of the standards of graduates in preceding years and action should be taken on the basis of that evaluation to continually improve the standard of graduates particularly in relation to the APCS.

THE PRIMACY OF A COMPREHENSIVE PHYSIOTHERAPY CLINICAL EDUCATION PROGRAM

It can be seen that in meeting Standard 1 of the ACOPRA Standards (and indeed integral to satisfactorily demonstrating the remaining four of the ACOPRA Standards) a program submitted for accreditation must demonstrate that students within such a program and graduating from it, have access to a comprehensive clinical education experience where clinical placements provide adequate breadth and depth. The demonstration of such adequacy of breadth and depth of supervised clinical practice is critical if institutions are to successfully demonstrate that they have a program whose graduates will meet the APCS Standards in all key areas of physiotherapy, across all ages and from acute to community contexts.

In 1997, when accreditation of physiotherapy education programs commenced, there were six programs leading to a degree in physiotherapy in Australian universities. In August 2005 the number of programs has increased to eighteen and an additional two universities are assessing the feasibility of offering physiotherapy programs. Thus in eight years there has been a 300% increase in the number of programs leading to a degree in physiotherapy. Whilst there has been a burgeoning of physiotherapy education programs over this period, the same cannot be said of growth in the health sector access to which is pivotal if students in these programs (and new ones that are to be offered) are to have adequate preparation as beginning physiotherapy practitioners.

All universities with physiotherapy education programs, and in particular universities offering such a program for the first time as well as universities with an existing bachelor degree in physiotherapy and offering in addition to it, a graduate entry master degree, must be sure that they can successfully demonstrate to ACOPRA that their students have a comprehensive program of supervised clinical practice.

Before planning to offer a new program in physiotherapy, institutions are urged to ensure that adequate clinical placement experience is available for the students who will enter the program. Furthermore, institutions should ensure that they are in a position to appoint early in the process, academic staff experienced in each of the key areas of physiotherapy practice.

Inability to successfully demonstrate that students in a physiotherapy program have access to a comprehensive program of supervised clinical practice may result in graduates emerging from a program that fails to receive accreditation, or a program the accreditation of which has been significantly delayed because of difficulties in providing the range and depth of clinical placements in all key areas of physiotherapy, across all ages and from acute to community contexts. In both cases this could have repercussions for graduates of these programs in the workplace.

Adopted by ACOPRA Council March 2003
Revised October 2004
Revised August 2005

AUSTRALIAN COUNCIL OF PHYSIOTHERAPY REGULATING AUTHORITIES LIMITED

Incorporating The Australian Examining Committee for Overseas Physiotherapists

ABN 28 108 663 896

Physiotherapy Mobility within Australia

Position Statement

The Australian Council of Physiotherapy Regulating Authorities endorses the following mechanisms to enhance the accountability of the profession and at the same time enhance the mobility of physiotherapists within Australia.

Adopted by the ACOPRA Board April 4 2004

Principles underlying the model

- The model could be implemented as an agreement between the Registration Boards in those States with the capacity to implement the model within their Act and would not be dependent upon all states participating.
- The participating Boards need to be satisfied that the registration requirements in the different States are sufficiently compatible with each other.
- Physiotherapists should be registered initially either in the State in which they reside or the state in which their main business is located.
- A physiotherapist registered to practise by one participating Board would be deemed to be automatically registered or have permission to practise (depending on the specific provisions) by other participating Boards for a limited period of time.
- The model would only apply to those physiotherapists with full registration without conditions, restrictions or limitations.
- Each authority would retain general discretion as to the granting of full registration under this model.

Summary of the mechanisms underlying the model

A person registered in the original State of registration (State 1) would have to "apply" for registration in the second or subsequent State where they wished to work (State 2). The application for registration should involve lodgment of a simple form with the dates of proposed work and the registration details from State 1, together with a certification of good standing, to the Board of State 2.

The physiotherapist should automatically be granted registration in State 2 based upon their State 1 registration. The Board in State 2 may then choose to implement a check of the registration status of the applicant in State 1.

Identified need for the model

Australia's physiotherapy registration is based upon State legislation and, currently, a physiotherapist must obtain registration in each State in which he or she wants to practise. Whilst Mutual Recognition has reduced some of the barriers to the movement of health practitioners between the States in terms of the ease of gaining registration in more than one State, the administrative requirements and costs that are still involved in gaining registration in more than one State are perceived by many to be too onerous and impractical.

The importance of the ease of mobility for Health Professionals has been highlighted by the Australian Health Ministers Advisory Council (AHMAC) as a means of reducing workforce shortages in some states. It has also been discussed in the following documents.

1) Medical Registration Discussion Paper

In a discussion paper on a Nationally Consistent Approach to Medical Registration[1], the importance of nationally consistent registration to assist portability in the current mobile workforce in response to developments in telemedicine was highlighted. The paper proposed a model of national portability of registration through administrative improvements and system improvements to mutual recognition arrangements.

[1] Nationally Consistent Approach to Medical Registration – A Discussion Paper, April 2002, www.health.gov.au/workforce

A driver's license model was discussed as a possible approach for improving registration portability. Under the driver's licence model, registration by one registering authority would provide permission to practise throughout Australia. That model would require amendments to both State and Territory legislation effectively deeming practitioners in one State to be entitled to practise in all participating jurisdictions.

2) Productivity Commission Draft Research Report

The Mutual Recognition Agreement was formulated in response to the frustration about the lack of progress towards uniform national regulation within Australia. A review of the Mutual Recognition Agreement and the Trans Tasman Mutual Recognition Arrangement was made in the Productivity Commission's Draft Research Report into Evaluation of the Mutual Recognition Schemes[2]. At page 74, the Draft Research Report referred to several submissions, which pointed to difficulties encountered by professionals who wished to practise temporarily in another jurisdiction[3].

The Draft Research Report referred to a submission from the Australian Veterinary Association that practitioners who provide advice or consultation interstate without registration in the jurisdiction have been sued and their indemnity insurance has failed to protect them.

The Draft Research Report noted that some professions in Australia avoid the difficulties by having a system of national registration to allow their members to practise in all Australian jurisdictions without any further paperwork or processes. Patent attorneys are federally regulated and their registration is recognized throughout Australia. The Standing Committee of Attorneys-General is working towards national legal profession model laws, to further harmonise regulatory requirements across jurisdictions (creation of a national practicing certificate).

The benefits for the wider community and for professionals by facilitating the temporary movement of professionals at low cost, while still retaining sufficient controls to ensure the maintenance of safety saw the Productivity Commission make the following preliminary findings:

[2] Evaluation of the Mutual Recognition Schemes, Draft Research Report, Productivity Commission, June 2003.
[3] Extract of Box 5.2 on page 75 of the Evaluation of the Mutual Recognition Schemes, Draft Research Report, Productivity Commission, June 2003

Preliminary Finding 5.5

There are likely to be net benefits from improving the capacity of registration systems to accommodate short notice applications for registration, to allow the short-term movement of professionals across jurisdictions.

Preliminary Finding 5.6

Australian occupational registration authorities should continue to consider developing national registration systems where the benefits justify the costs.

Health professionals generally and physiotherapists in particular have increasing demands for mobility on their professional practice and for professional development. With the growth in the role of physiotherapists within elite sporting and cultural organisations combined with the increasing development of national codes of participation, more and more physiotherapists are required to travel with their teams or groups interstate on a regular basis. With growing advances in technology, physiotherapists will need to be registered in the State in which the patient resides when they assess and advise patients using technological links such as tele-physiotherapy.

Application of the model

The model will provide practitioners with the opportunity for greater mobility when they are working interstate for short periods. These provisions would apply even if the practitioner is only practising on members of his/ her own team or cultural group from the original state.

The model is not to be used where a practitioner, having a primary practice in one state, operates a part time practice in another state on a regular basis. The model is for those persons who work for a short, transient period in another state, to remove the inconvenience and expense of registering in each jurisdiction. The model can also be used by those practitioners participating in an intermittent way in telephysiotherapy and are required to be registered in the second state where the patient or patient group is located at the time of the consultation.

It is proposed to limit the total amount of time that a practitioner could practise in another state within a one year period before they would be required to apply for full registration in the second state (for example not more than 90 working days).

The model is not dependent on all states participating. It could operate between a limited number of states that were willing and had the legislative capacity to participate.

The risks to public safety associated with this model are essentially equal to those inherent in the current one month "changeover period" of the mutual recognition process. The risks, however, have been minimized with the accreditation of entry programs and a national process for the examination of overseas physiotherapists, which has seen a nationally adopted process of assessment of standards of physiotherapy. Although individual States have different requirements for recency of practice, the proposed arrangements could still be implemented.

The model endorsed by ACOPRA

The model is based on what is called the "drivers licence" model. Under the "drivers licence" model, a physiotherapist registered with one state board would be deemed to be automatically registered or have permission to practise (depending on the specific provisions) by other State Boards for a limited period of time. This approach may require amendments to State and Territory legislation to deem practitioners registered in one State to be entitled to practice in all Australian participating jurisdictions.

These provisions would only apply to those physiotherapists with full registration without conditions. A person registered to practise in the original State of registration (State 1) would have to "apply" for registration in the state where they wished to work (State 2). The application for registration could involve the following process:

- a simple notification to the Board of State 2 of the dates of proposed work in that jurisdiction, contact details, registration number, expiry date of registration, certification of good standing and relevant Board details
- A physiotherapist would automatically be granted registration in State 2 based upon his or her State 1 registration.

It is challenging to balance the competing needs of mobility for physiotherapists and accountability for public safety. If there were no notification requirements, it would be very difficult to trace a physiotherapist against whom a complaint was made when they were practising in State 2 if there was no record of the physiotherapist held by State 2.

Therefore, some record of State 2 registration must be maintained but it is recommended that the administration of this be as simple and convenient as possible with electronic lodgment of the physiotherapist's details as an option. The Board in State 2 may wish to implement a check of the registration status of the physiotherapist in State 1. The mobility model implies that no collection of fees takes place by the State 2 Board.

Outcomes from the model

The endorsed mobility model addresses the problems which are currently experienced by many physiotherapists with national commitments in order to register to practise in each State and Territory to which they travel. It would be possible for the model to accommodate a practitioner based primarily in the originating state, working in another state for:

a) Approximately 3 months on a continuous basis; OR

b) one day a week working for 12 months; OR

c) short periods for interstate events.

The endorsed model is therefore seen as an effective way of facilitating the temporary mobility of professionals at low cost with benefits for the wider community and for individual physiotherapists, while still retaining sufficient controls to ensure the maintenance of safety and protection of the public.

Adopted 29 March 2003

AUSTRALIAN COUNCIL OF PHYSIOTHERAPY REGULATING AUTHORITIES Inc

Incorporating The Australian Examining Committee for Overseas Physiotherapists

ABN 23 789 342 710

LIMITED REGISTRATION

Consistent national criteria and conditions prepared in collaboration with the APA

Background

There is a national shortage of physiotherapists, substantiated by Department of Employment and Workplace Relations research (2002) and Australian Institute of Health and Welfare (AIHW) publications. The shortage of physiotherapists is worse in rural and remote regions and within particular clinical specialties such as gerontology, respiratory medicine, neurology, oncology, disability and paediatrics.

Vacancies significantly outnumber physiotherapists seeking work in APA job banks and anecdotal reports of physiotherapy workforce shortages are also strong and increasing. Apart from the impact on work force supply, the viability of positive programs such as the Working Holiday Maker scheme and professional exchange programs is threatened.

Since the abolition of the grouping system for **full registration**, the Registration Boards' ability to respond with the same degree of flexibility has been significantly reduced. While the recent changes apply to the application for full registration, some Boards still have the capacity to grant some form of **limited registration** such as temporary, provisional or conditional.

In the light of the obligations under Mutual Recognition Agreement and the objects of ACOPRA to establish consistent national criteria for registration, it may be valuable to provide a consistent national approach to the conditions and criteria that could be applied by Boards when considering various forms of limited registration in the context of overseas applicants.

Some Boards have already adopted criteria for acceptance of overseas qualified practitioners with Working Holiday Visas. It would be an excellent outcome if agreement on a consistent national approach was able to be reached before anomalies arise to create difficulties.

It is recognised that there is a need to maintain standards of practice and that there are frequent changes made to existing programs and new programs emerging overseas. At the same time, the workforce shortage is becoming a critical professional issue that affects consumer access to physiotherapy services, morale and retention within the existing workforce, economic viability of some services, and advancement of the profession.

The mechanisms proposed

These nationally consistent criteria and conditions for some form of limited registration are now available for consideration and implementation by individual Registration Boards within the context of their specific Physiotherapy Acts. It may be that in some states, legislation does not permit limited registration and in others more stringent criteria may need to apply for example, shorter time frames. In general terms the criteria and conditions include:

- Defined grouping of potential applicants who would have a similar training and have experience in similar working conditions as Australian graduates.
- Specified minimum level of experience prior to consideration.
- Referee input.
- Contracted assurance of supervision whilst practicing in Australia.
- Established criteria for those providing the supervision.
- Registration limited to specified physiotherapy facilities i.e. site-specific restricted registration.
- Defined time frames i.e. registration is limited in time usually no more than 12 months.

The criteria

1. The course content of the physiotherapy qualification should include theoretical and clinical components of cardio-respiratory, musculo-skeletal and neurological physiotherapy and of electrotherapy similar in duration to an Australian qualification.
2. A period of paid employment in clinical practice under conditions equivalent to practice in Australia for at least 12 months out of the previous two years..
3. Applicants must provide 2 referees to substantiate a reliable and competent work history and good character since graduation. At least one referee must be a physiotherapist who has supervised the applicant during the previous 12 months.
4. The applicant is or is entitled to be registered or licensed to practice as a physiotherapist in the country in which the course was taken.
5. If the applicant is from a country where English is not their first language, they must be able to demonstrate that they have a comprehensive knowledge and satisfactory level of skill in English. A “B” pass in all four sections of the Occupational English Test (OET) or an overall score of Band 7 (with a minimum of Band 6 in each of the 4 components) in the Academic module of the International English Language Testing System (IELTS) will satisfy this requirement if gained within 12 months of application.

The conditions

Required:

1. Applicants must be "hosted" to work within a defined physiotherapy facility within Australia. The host must be a registered Australian physiotherapist who satisfies agreed eligibility criteria.
2. The host must enter into a contractual agreement with the relevant physiotherapists' registration board in respect to their obligations under this model.
3. The employer must be able to provide supervised clinical practice where the nominated supervisor is on site with the physiotherapist at all times.
4. Applicants must hold valid professional indemnity insurance to the value that is accepted by the profession.

Desirable:

5. The employer should be associated with a health service provider or private practice large enough to have supportive structures such as in service training, quality improvement activities and supervision
6. The health service provider or private practice should be accredited with an appropriate body such as the Australian Council of Healthcare Standards or the Australian Physiotherapy Association.

Host eligibility criteria

1. Registered physiotherapist.
2. Supervisory experience of clinical practice (within Australia) within previous 5 years.
3. Familiar with the Australian Physiotherapy Competency Standards and the APA Code of Conduct and any Board Code of Conduct and policies for physiotherapists.

Facilitating the "hosting process"

The APA has offered to act as an agent to facilitate the hosting process. This service could be provided as an internet-based facility through the APA website with links to and from the ACOPRA website. It is understood however, that this "agency" would be offered independently of Board processes and applicants would not be obliged to use this service.

Summary

ACOPRA Council agreed by majority vote at its meeting on 29th March, 2003 on these conditions and criteria for a consistent national approach for overseas physiotherapists applying for limited forms of registration.

The Council would like to recommend these conditions and criteria for consideration and implementation by individual Registration Boards within the context of their specific Physiotherapy Acts.