

Cancer care and health professional accreditation

Joint submission in response to the AHMAC consultation paper, *Proposed arrangements for accreditation*

December 2008

The Clinical Oncological Society of Australia is the peak multidisciplinary society for health professionals working in cancer research or the treatment, rehabilitation or palliation of cancer patients.



Cancer Council Australia is Australia's peak non-government national cancer control organisation. Its member bodies are the eight state and territory cancer councils, whose views and priorities it represents on a national level.



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Overview

COSA and Cancer Council Australia welcome the opportunity to comment on the consultation paper, *Proposed arrangements for accreditation*. Our input comprises general commentary, as well as specific comments in relation to particular proposals in the paper.

We are encouraged that key factors in the proposed new scheme are ensuring public protection (which we infer as patient care outcomes) and a high degree of transparency and accountability. To a significant extent, these priorities are already underpinned by a number of the measures currently in place to train and register the cancer care workforce.

The key to any reforms in healthcare professional accreditation will be enhancing and streamlining what is already in place, without risking a diminution of care standards and outcomes. Therefore, while we welcome elements of this reform, we also recommend caution in any wholesale change to current arrangements.

General comment

While we understand that the accreditation and registration processes under review by COAG are system-wide, we make the case that particular focus needs to be on ensuring any reforms contribute to improvements in (and do not compromise) cancer care outcomes.

Cancer in Australia

Ensuring an efficient and cost-effective cancer care workforce should be integral to any proposed changes in health professional accreditation for a number of reasons, including:

- Cancer accounts for more premature deaths in Australia than any other individual cause;¹
- One in two Australian men and one in three Australian women is likely to be diagnosed with cancer by age 85;²
- Cancer survival is increasing significantly, meaning a greater number and range of health professionals will be involved in cancer patient care and in expanded treatment settings including non-metropolitan and community settings;³
- Cancer incidence will have increased by around a third in 10 years between 2002-11,⁴ with this trend likely to continue until population ageing peaks in 2047;⁵
- Cancers are the second most costly disease group to treat in Australia through the hospital system,⁶ reflecting the complex, multifaceted nature of professional cancer care;
- Almost two thirds of the \$3.7 billion spent in 2006-07 on cancer treatment in Australia was absorbed in hospital services, the highest proportion of any major disease group;⁶
- A declining taxpayer base and an increasing patient caseload suggest that more will have to be done with less in order to treat Australian cancer patients until population ageing peaks. Any reforms to address this requirement for increased efficiency at lower cost through accreditation must ensure that patient care is not compromised; and
- Effective policy in cancer care training, planning and professional support has flow-on benefits throughout the health system.

Priority 1: ensure we do not go backwards

Continuous improvement is a pillar of professional development in health care. While there is clearly a need to better support the cancer care workforce (e.g. training, core competencies, use of clinical practice guidelines, career support etc.), an imperative in this reform exercise is to first ensure there is no risk that cancer care outcomes are compromised as a result.

We emphasise this point in the knowledge that cancer survival in Australia has consistently improved since 1982³ and that Australia has one of the world's highest cancer survival rates.⁷ While distinct population groups continue to be marginalised (e.g. Indigenous Australians, people in remote locations) and some tumours are very difficult to treat, in general terms an Australian living in a major metropolitan or inner regional centre who is diagnosed with cancer is likely to have access to treatment services that, against international benchmarks, are demonstrably efficient, effective and subject to a high level of regulation and peer scrutiny.

We therefore recommend caution in any systemic change, particularly if the ultimate aim may be to reduce health system costs. In our view, as discussed in detail against specific proposals in the consultation paper, effective change could be achieved without developing an entirely new structure. Streamlining current arrangements could be achieved through the establishment of a national coordinating body without requiring comprehensive systemic change.

Where new accreditation arrangements will require health professionals to meet additional standards, it is important that commensurate training and career support are available to assist in the development of relevant competencies. (See Cancer Council Australia's [Ideal Oncology Curriculum](#).)

Funding arrangements

COSA/ Cancer Council Australia are concerned with suggestions that, following an initial government contribution through the transition phase, a new national accreditation scheme would be “self-funding” – i.e. funded by revenue raised through (presumably higher) registration fees. We are concerned that this approach has the potential to impose an additional cost on health professionals, many of whom already pay inflated premiums for medical indemnity, and will add a new layer of bureaucracy on a highly bureaucratised profession.

While we support tightening and streamlining accreditation processes nationally along the general lines proposed by COAG, we contend that this could be achieved without an additional cost burden to individual professionals – in large part by boosting the efficiency and coordination of processes already in place, rather than creating an entirely new (and potentially cumbersome and costly) system.

It is important to note that health services face increasing competition from a range of sectors to recruit, train and retain high-achieving graduates and to support healthcare professionals throughout their careers. Moreover, evidence shows a growing number of oncology professionals are showing career burnout, encouraging them to leave the field.⁸

An entirely new accreditation system that requires health professionals to improve their standards in order to be registered, then charges them an increased registration fee for their efforts, could be counterproductive.

Building on pre-existing work

As discussed throughout this document, the prevalence, complexity and burden of cancer call for a tailored approach to the accreditation of cancer care professionals. The Australian Cancer Network (a broad-based collaboration of cancer clinicians, under the auspices of Cancer Council Australia and COSA) has developed two important documents on the credentialing of cancer care professionals (“credentialing” in this context means the same as accreditation):

- A detailed scoping document that explores the methods and processes for credentialing clinicians who provide cancer services; and
- a template that healthcare organisations could use in credentialing cancer clinicians.

These documents are available online at:

<http://www.cancer.org.au/Healthprofessionals/AustCancerNetwork/Credentialling.htm>

It is important to note that these documents were developed on the basis of work previously undertaken by the Australian Council for Safety and Quality in Health Care on credentialing clinicians more generally, which was endorsed by all Australian health ministers in 2004.

The Cancer Institute NSW has also done considerable scoping in this area, including published reports on the principles of accreditation; proposed frameworks and a gap analysis; and a literature review.

There is, therefore, a wealth of information that can be factored into improved system efficiency without necessarily building an entirely new structure.

Political/bureaucratic interference

One of the pillars of evidence-based healthcare is the development of professional standards and ethics independent of politics and of bureaucratic processes, which are often driven by economic priorities.

While we welcome the opportunity to contribute to this process and assume it is being promoted in the interests of improved development, monitoring and accountability of the health workforce, COSA/ Cancer Council Australia recommend greater clarity in separating the roles of government and independent healthcare professionals. For example, in the discussion paper the make-up of the “Ministerial Council” (Australian Health Workforce Ministerial Council) – and the extent to which its decisions will be made independently of political priorities – appears unclear.

A whole-of-government approach and national coordination to improve health professional accreditation has the potential to reduce red tape. However, if appropriate processes are not in place to safeguard the independence of evidence-based clinicians and other healthcare professionals in contributing to accreditation decisions, service standards – and patient outcomes – could be compromised.

Comments in response to specific discussion paper proposals

Proposal 3.4.1: It is proposed that in preparation for commencement of the national scheme, national boards will consider whether there is a need for specialist endorsements in their profession.

COSA/Cancer Council Australia comment: In considering specialist endorsements, it is imperative that national boards representing cancer specialists follow the principles set out in the [Australian Cancer Network recommendations](#) on specialist accreditation and credentialing – particularly in relation to caseload. Where flexible approaches are necessary in the absence of sufficient caseload or, for example, in rural/remote settings, minimum requirements for specialist endorsement should include:

- the technical skills to undertake specialised aspects of cancer care safely and competently;
- adherence to the principles of patient-centred care;
- the capacity to recognise and carry out at least the initial management of any complications that may arise;
- access to evidence-based best practice, including the use of clinical practice guidelines and/or protocols recommended by specialised cancer units;

- a demonstrated understanding of multidisciplinary care; and
- mandatory compliance with processes for regular performance review.

Proposal 3.4.2: In the case of the medical profession, it is proposed that the national board take advice from the Australian Medical Council on the list of specialties and associated specialist qualifications, against which the board could endorse individual registrants as specialists.

COSA/Cancer Council Australia comment: This proposal has the potential to deliver improved efficiency. However, it is important that efficiency be balanced against maintaining (and continually improving) care standards in increasingly specialised fields. We therefore recommend that the input of specialty and subspecialty groups (e.g. COSA, and its specialist and subspecialist members such as the Medical Oncology Group of Australia) into decisions by the national board be formalised, as a supplement to advice provided by the Australian Medical Council.

Proposal 3.4.3: It is proposed that in line with the IGA the national scheme legislation will provide that while boards may approve the initial list of specialties, any new specialties or specialty areas of practice will require Ministerial Council approval.

COSA/Cancer Council Australia comment: It is unclear in the consultation paper whether the “Ministerial Council” will comprise independent clinical representation. We are therefore concerned that there is a risk that decisions around specialisation, subspecialisation and associated accreditation will be driven by political/bureaucratic priorities. For example, subspecialties in fields such as geriatric oncology and adolescent/young adult cancer need to be developed in response to increasing need and comparatively poor outcomes respectively. At present, development in these areas are being driven exclusively by clinicians and consumers, who deal routinely with the practical barriers to improved outcomes caused in part by a lack of subspecialisation; clinical representation should be essential to any formal procedures to approve specialties, particularly in relation to highly prevalent, high-mortality disease groups such as cancer.

Proposal 3.4.4: It is proposed that the Ministerial Council specify that the core accreditation functions initially assigned to the external accreditation bodies are the core functions listed [in the discussion paper] where those functions are currently undertaken by the body.

COSA/Cancer Council Australia comment: We support the core accreditation functions set out in the discussion paper, provided there is scope to extend these functions for specific cancer care professions, in consultation with cancer professional groups including COSA. As per our response to 3.4.3, it is imperative that independent clinicians have a formal role in these decisions.

Proposal 3.4.5: It is proposed that the Ministerial Council specify that it would be open to boards to delegate to external accreditation bodies or committees other functions related to

accreditation or other matters for which the boards have responsibility, but the boards would not be required to do so.

COSA/Cancer Council Australia comment: We support the notion of boards potentially outsourcing specific components of accreditation, provided boards retain independent control of such decisions, sound governance arrangements are in place to ensure care standards are not compromised by any co-opting of external entities, and that the boards are comprised of (and chaired by) independent healthcare professionals from the relevant discipline.

Proposal 3.4.6: It is proposed that the national scheme legislation allows for changes and expansion of the range of courses accredited with any such expansion requiring the approval of the relevant standards by the Ministerial Council.

COSA/Cancer Council Australia comment: This proposal is supported in principle, however we emphasise that its appropriateness and effectiveness will depend on sound governance arrangements – e.g. the Ministerial Council would need to ensure its decisions on standards are supported by independent clinicians and other health professionals with relevant specialist expertise across disciplines.

Proposal 3.4.7: It is proposed that the legislation provide general powers of delegation to boards allowing them to delegate other functions to external accreditation bodies where they consider this is the best way to achieve the objectives of the national scheme and where this is consistent with their powers under the legislation.

COSA/Cancer Council Australia comment: Provided the boards are comprised of healthcare professionals from relevant disciplines and able to function independently of the political process, we support this proposal. (Co-opting board members with other skills and experience – e.g. consumers, legal etc. – may be desirable, provided clinicians and other health professionals are satisfied there is no risk of compromised care standards.)

Proposal 3.5.1: It is proposed that the agency's requirements in relation to the national scheme should be specified in the contract with the specific accreditation body.

Proposal 3.5.2: It is proposed that the terms of contracts between the agency and the external accrediting body include but are not limited to, the following matters:

- (a) The objectives of the national scheme
- (b) The accreditation framework standards developed by the agency
- (c) The budget for the accreditation functions it is performing for the national board
- (d) The contribution to the cost of those functions to be drawn from registration fees
- (e) Monitoring and reporting arrangements
- (f) Requirements relating to contributions to the national board's annual report, and
- (g) Provisions relating to termination of the contract.

Proposal 3.5.3: It is proposed that the arrangements between the agency and any external accreditation body form part of the health profession agreement between the agency and each national board, providing both the national board and the agency with input to the arrangements.

COSA/Cancer Council Australia comment: The major concern in this context is that the requirement for registration fees to fund accreditation functions does not result in additional out-of-pocket costs for healthcare professionals. At a time when high-achieving students are increasingly attracted to careers in fields other than healthcare, retention of healthcare professionals is more difficult and overheads such as indemnity insurance etc. are becoming ever more burdensome, it is important to ensure that the costs of establishing a new accreditation system are not borne by the professions.

This is particularly relevant in cancer care, where evidence in terms of patient outcomes shows Australian clinicians are generally adhering to high professional standards; we therefore support improved efficiency, rigour and transparency in professional accreditation, but moves to establish an entirely new structure could be counterproductive if it imposes costs on the professional. (It is also important to note that a large proportion of health professionals are already paying members of multiple professional groups.)

Proposal 3.5.4: It is proposed that the national scheme legislation provide that the agency must consult with the boards on the development of the standards to govern registration and accreditation processes within the scheme.

COSA/Cancer Council Australia comment: Provided the boards are appropriately staffed and structured, this proposal is supported. It is important to note that substantial work on care standards in relation to cancer professional accreditation and credentialing has already been undertaken; the principle aim of any reforms in this area should be to ensure greater efficiency by building on work already undertaken by the Australian Cancer Network and the Australian Commission on Safety and Quality in Healthcare.

Proposal 3.5.5: It is proposed that the external body assigned to undertake accreditation in the first three years will have the ability to delegate parts of the accreditation function to other agencies, while it remains responsible for the overall function, where there is no conflict of interest and where this was the arrangement at the time the accreditation function was assigned.

COSA/Cancer Council Australia comment: This proposal is supported in principle.

Proposal 3.5.6: As per Bill A, it is proposed that the national scheme legislation provide that the accreditation bodies and committees of the national board be required to consult widely when developing standards for accreditation.

COSA/Cancer Council Australia comment: This proposal is supported, provided there is clarity and consistency around the notion of “consulting widely” – e.g. consultation on standards

for accreditation must include seeking the views of professional groups in all disciplines involved in disease-specific healthcare, along with a mechanism to ensure such professional views are incorporated into the standards.

Proposal 3.5.7: It is proposed that the national scheme legislation provide that the agency be required to publish on its website, the standards for accreditation following approval by the Ministerial Council as well as all fees and charges related to accreditation.

COSA/Cancer Council Australia comment: This level of transparency is supported.

Proposal 3.5.8: It is proposed that the contract with the external accreditation body require that body to provide information to the national board on financial reports pertaining to accreditation functions, activities undertaken during the year, including standards developed, courses accredited or monitored, the number of qualifications assessments of overseas trained practitioners undertaken and the decisions made as a result of these assessments, and anything else requested by the national board, for inclusion in the agency's annual report.

COSA/Cancer Council Australia comment: This level of transparency is supported in principle, provided the administrative costs are not passed onto individual healthcare professionals.

Proposal 3.6.1: It is proposed that the Ministerial Council require that accreditation committees comprise two registered practitioners from the relevant profession, two members with education and training expertise, two community members and two representatives from the relevant national board.

COSA/Cancer Council Australia comment: This proposal is supported in principle. It appears, however, to be at odds with Principle (b) (page 6): "ensure that the process of assessment of courses and qualifications is undertaken independently from government, health professional educators and the profession". While independence is a vital component of effective accreditation, it is unclear how courses and qualifications can be adequately assessed if "health educators and the professions" are excluded in the interests of independence.

Proposal 3.6.2: It is further proposed that the Ministerial Council require that the relevant national board appoint an accreditation committee chair from among these members.

COSA/Cancer Council Australia comment: This proposal is supported in principle.

Proposal 3.6.3: It is also proposed that the Ministerial Council require that the process by which the national board selects members for an accreditation committee be open and transparent. Positions should be advertised and allow for expressions of interest from individuals and nominations from groups.

COSA/Cancer Council Australia comment: This proposal is supported in principle.

Proposal 3.6.4: It is proposed that the legislation will give general delegation powers to boards allowing them to delegate other functions to agency staff and committees, as well as external accreditation bodies, where they consider this is the best way to achieve the objects of the national scheme and it is consistent with their powers under the legislation.

COSA/Cancer Council Australia comment: See response to proposal 3.4.5.

Proposal 3.7.1: It is proposed that any organisation disadvantaged by an accreditation decision of the board should have the right to seek a merit or process review and, if required, go beyond that to an external process of review.

COSA/Cancer Council Australia comment: This proposal is supported in principle.

Proposal 3.8.1: It is proposed that the national scheme legislation will provide that all bodies and their agents under the scheme will be indemnified for work performed in relation to the scheme. These indemnity arrangements will extend to external accreditation bodies and committees and persons acting for those bodies and committees.

COSA/Cancer Council Australia comment: While indemnity for accreditation agents/agencies is essential, it appears unclear in the discussion paper who the insurer would be. We make the case that government is the appropriate body to provide overarching indemnity to individual healthcare professionals and professional organisations formally participating in the accreditation process in any way that incurs potential legal risk; we recommend that the government's responsibility is clarified in the inter-government agreement and in any relevant legislation as appropriate. It is imperative that individual healthcare professionals and independent professional organisations are not expected to indemnify themselves in order to contribute their expertise and experience to the accreditation process.

Proposal 3.10.1: It is proposed that the Ministerial Council request that the agency consider the following matters in developing standards for accreditation processes:

- (a) the document *Standards for Professional Accreditation Processes* developed by 'Professions Australia' in consultation with the Forum of Health Professions Councils
- (b) the need to meet any relevant international guidelines relating to the specific professions
- (c) the need to align standards with relevant international standards and clearly indicate the international standards on which these standards are based when presenting them to boards for consideration, and
- (d) the need to ensure that accreditation assessment panels provide sufficient public accountability and independence.

COSA/Cancer Council Australia comment: We note that the work of Professions Australia, in consultation with the Forum of Health Professions Council, promotes sound general principles of accreditation and mechanisms for their implementation. In a healthcare field as complex and prevalent as cancer, this core work should be complemented by the substantial scoping

exercises already undertaken by the Australian Cancer Network. It is therefore recommended that the Ministerial Council also requests that the agency developing standards considers specific advice in relation to major disease groups, to ensure there is adequate tailoring of arrangements to support professional development in specialised but high-volume work.

Regarding alignment with international standards, it is important to note that some of the world's leading developmental work on accreditation/credentialing for cancer care professionals has been undertaken in Australia by the Australian Cancer Network; and the comparatively good cancer care outcomes in Australia indicate that key elements of the current system are working well by international standards.

COSA/Cancer Council Australia support the need for a high level of public accountability and independence (including independence from the political process) in accreditation.

Proposal 3.10.2: It is proposed that the legislation provides for ongoing monitoring of education courses and institutions, including requiring accredited education providers to report to the accreditation body or committee any significant curricular changes or resourcing issues that would adversely impact on students and compromise their ability to register, and requirements for the accreditation body or committee to report any such adverse events to the relevant national board as soon as it becomes aware of them.

COSA/Cancer Council Australia comment: This proposal is supported, particularly if it provides for continuous improvement in professional development to treat major diseases like cancer.

If the proposal is endorsed, it is a timely opportunity to expand current medical training curricula to include an [Ideal Oncology Curriculum](#). Developed by our Oncology Education Committee and endorsed by the International Union Against Cancer, our [Ideal Oncology Curriculum](#) aims to ensure minimum standards of knowledge and skill in cancer management are attained at graduation from medical school. Despite its international recognition, there are no mechanisms to promote the curriculum's use in Australian medical schools – at a time when studies show overall cancer competencies among medical trainees are in comparative decline.⁹

Proposal 4.1: It is proposed that accreditation reports will be made publicly available in the agency's annual report and on its website. These reports will include recommendations and outcomes of accreditation processes and information on education and training courses.

COSA/Cancer Council Australia comment: This proposal is supported in principle.

Proposal 5.1: It is proposed that the national scheme legislation provide that standards for accreditation are developed in consultation with New Zealand and any other country with which Australia has (or develops) a mutual recognition agreement.

COSA/Cancer Council Australia comment: This proposal is supported in principle.

Proposal 6.1: It is proposed that transitional arrangements to be included in the national scheme legislation will include requirements for:

- (a) current boards to provide the new national boards with their lists of accredited courses prior to the commencement of the national scheme
- (b) standards for courses or education providers which exist on 30 June 2010, to continue until they are replaced with standards developed under the national scheme and approved by the Ministerial Council
- (c) education and training courses and education providers which are accredited by the current boards on 30 June 2010 to be deemed to be accredited under the national scheme until they have been re-accredited under the new provisions, and
- (d) lead times of at least one full year for the introduction of any new accreditation standards following approval by the Ministerial Council to allow course providers to make any required changes to their courses.

COSA/Cancer Council Australia comment: See response to proposal 3.10.2 – this proposal could also provide opportunities to improve cancer competency through the application of an Ideal Oncology Curriculum.

References

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⁸ Grunfeld, E., Whelan, T.J., Zitzelberger, L., Willan, A.R., Montesanto, B. & Evans, W.K. 2000, 'Cancer care workers in Ontario: prevalence of burnout, job stress and job satisfaction', *Canadian Medical Association Journal*, vol. 163, pp. 166-169.

⁹ Barton MB, Tattersall MHN, Butow P, et al. Cancer knowledge and skills of interns in Australia and New Zealand in 2001: comparison with 1990, and between course types; *MJA* Vol 178, 17 March 2003.