Accountability and accreditation in the Australian allied health context

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Abstract

This paper examines the professional accreditation systems developed by five allied health associations in Australia. Professional accreditation is potentially a powerful tool because it can describe both the attributes of a health service provider and aspects of the quality of their care. This information is of value to patients, regulatory bodies and funding organizations to guide their health service decision making. However, the lack of consistency in the approaches used by the allied health disciplines means that the term 'accreditation' has a different value for each profession. Additionally, patient and purchaser preferences have received little consideration in the development of the accreditation systems. Thus, the ability of external purchasers, regulators or patients to use accreditation status to guide decision making is limited at best, and at worst risks devaluing the approach at an interdisciplinary level. In this paper we present the range of interpretations of professional accreditation adopted by the podiatry, physiotherapy, occupational therapy, dietetics and nutrition and social work associations in Australia. Based on the interdisciplinary variations we argue for the development of a consistent approach to professional accreditation standards and guidelines.
**Introduction**

The term 'accreditation' is derived from the Latin 'accreditus', which means to give credence or official authorization for compliance with a particular standard (Merriam-Webster Incorporated 2001). The applications and interpretations of accreditation in practice vary widely. In health care, accreditation is often applied to organizations, as the following quote from the International Society for Quality in Health Care illustrates;

*Accreditation is a self-assessment and external peer review process used by healthcare organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the healthcare system (Tregloan 2000:1).*

However, individuals can be accredited as an indicator of their competence to carry out particular tasks (International Organisation for Standardisation 1992). Accreditation is normally provided by an external body or agency. In the allied health context, accreditation can be described as a way of giving individuals or organizations, who agree to adhere to particular standards, an enhanced level of recognition.

Accreditation is distinct from professional regulation, although there is some overlap in the goals of each. Regulation, where it exists, tends to be a statutory requirement, reinforced through the registration of practitioners at a state or territory level. For the disciplines described in this paper, registration establishes the minimum entry requirements to the profession and is often based on the attainment of an educational qualification. As Table 1 illustrates, there are some variations across states and disciplines. Where registration is available, the provider is required to be registered in order to use a professional title or achieve professional closure.
Accreditation, on the other hand, allows the practitioner to demonstrate that they are upholding particular standards across a number of domains. Accreditation is currently offered by professional associations which are the bodies that represent and promote the interests of members from their corresponding disciplines. Participation in accreditation programmes is voluntary for most disciplines.

Accreditation is not new. The earliest accreditation standards in health care were proposed by Ernest Codman in 1912, and modified by the American College of Surgeons in 1917 (Sharpe 2000). It is a way of making the allied health professional accountable for the standard of service they provide. However, the importance of health service provider accountability has been reinforced over recent decades by neo-liberal management structures, increased consumer sovereignty and the desire to contain health care costs (Gladstone 1993; ACTCOSS 1999; Bethell 1999; Relman 1988). The cumulative impact of these factors has been an increasing need for transparency in health service delivery and accountability. Accreditation is, in theory, one mechanism through which health service providers can be proactive in demonstrating that they are adhering to a certain standard of care, whilst removing the onus of proof from the purchaser, user or regulator of that care.

A range of stakeholders can potentially gain from the introduction of professional accreditation. Consumers stand to benefit through the provision of an explicit set of guidelines that explains aspects of the quality of care they receive. Similarly, regulatory bodies, such as registration boards could use accreditation systems to establish that minimum standards have been met and to augment the commonly used criterion of an educational qualification. Funders and purchasers can use accreditation systems as a way of determining which services should be purchased, although to date, accreditation is not used to inform purchasing decisions for the majority of allied health professions in Australia.
The accreditation label itself has little intrinsic meaning. Health service users, purchasers and regulators cannot make informed decisions on the basis of accreditation status if they do not first have some understanding of the concepts that underpin it. This becomes problematic where there is a lack of consistency in the approach to accreditation used by different professions. The key components of any accreditation system can be described in terms of the domains for which providers can be held accountable and the procedures through which adherence to the systems can be determined (Emanuel & Emanuel 1996).

The *domains* are the activities, issues or practices for which the parties can be held responsible and called on to justify or change their actions. Examples of the domains of accountability include professional competence, legal and ethical conduct, financial performance, adequacy of access and the delivery of quality care (Ray 1999; Emanuel & Emanuel 1996).

Each domain has a specific content area that forms the criteria against which the domain is both defined and evaluated. The methods of evaluating performance against these criteria can be explicit or implicit. Explicit performance evaluation includes systematic audits of files, reporting against contractual requirements, the publication of mortality rates and monitoring providers on the basis of the types and volume of services they provide. Implicit performance criteria could include the perceived quality of providers based on press reports or word of mouth.

The *procedures* of accountability include both the evaluation of the degree of adherence to the criteria for specific content areas and the dissemination of these results by the accountable parties. The methods of evaluation differ according to the area of accountability. Formal procedures include the inspection of facilities, records and policies, audit, registration and complaints procedures. Informal mechanisms include the undocumented interactions between
the health service provider and patient, press or media based evaluations and reports.

This paper examines the domains and procedures of accountability used by five allied health professional associations in their accreditation systems.

**Method**

The five disciplines included in this study are dietetics, occupational therapy, physiotherapy, podiatry and social work as these represent a sample of the health and social care professional bodies that have introduced accreditation systems in Australia. This study drew on data from a variety of sources including the relevant professional association Internet sites, policy statements, the Australian Institute of Health and Welfare Labor Force Statistics (AIHW 1996) and interviews with relevant personnel within the professional associations. Prior to submission for publication, the participating professional associations were presented with this paper to corroborate or correct results. Feedback was received from all disciplines with the exception of social work, who reported that they were too busy to respond.

**Results**

The workforce profile of the allied health disciplines is summarised in Table 1. The workforce numbers are indicative only as the most recent national census with available data was undertaken in 1996 (AIHW 1996). The Australian Institute of Health and Welfare undertook more labour force surveys in 1998, but the reports have not been published for all professions. As a result, Table 1 illustrates the most recent published data or recent estimations from the professional associations.

Physiotherapy represents the largest proportion of allied health service providers in the survey, with around 11400 professionals. Podiatry is the smallest profession with approximately 1700 providers. The minimum standard for entry into any of the professions
is a Bachelor degree, which takes three or four years to complete. Registration requirements vary within states and between disciplines. Physiotherapy is the only discipline in which providers are required to register in every state and territory.

Membership to professional associations in Australia is voluntary and requires the members to pay a fee. As a result, membership varies from an estimated 60% of occupational therapists to 85% of podiatrists.

**INSERT TABLE 1 ABOUT HERE**

The accreditation system developed by each discipline is summarised below, with key details presented in Table 2, including the proportion of accredited providers, cost of accreditation, benefits of accreditation to the providers (such as increased reimbursement for their services) and how the public is informed about the providers' accreditation status. Table 3 illustrates the key domains and procedures of accountability for each of the disciplines. In all cases except physiotherapy, the professional association accredits individual practitioners. The Australian Physiotherapy Association provides accreditation for physiotherapy practices or departments.

**INSERT TABLES 2 AND 3 ABOUT HERE**

**Dietetics and Nutrition**

Dietitians are able to participate in the Accredited Practicing Dietitian Programme (APD) established in 1994 by the Dietitians Association of Australia. To be successful in the Programme, applicants must

"plan a personal Continuing Development Programme; provide records of the CPD activities that they have undertaken throughout the year; confirm their commitment to the DAA Code of Professional"
Dietitians are required to provide evidence of at least 30 hours spent in continuing professional development activities each year. The activities are divided into six domains and the arrangement of activities is left to the discretion of the Dietitian. The domains are (1) Conferences, workshops, lectures, seminars and short courses; (2) External study programmes and Self study programmes; (3) Employer provided activities; (4) Teaching and research activities; (5) Quality management; and (6) Mentoring. Once providers have accumulated sufficient time on their Log sheets, confirmed their commitment to DAA and paid the programme fee they are eligible to apply for accreditation. The Accredited Practising Dietitian Programme runs on an annual cycle.

Occupational Therapy

OT AUSTRALIA introduced the Accredited Occupational Therapist Programme (AccOT) in April 2001. Occupational therapists are accredited through the assessment of Continuing Professional Development records. Providers must agree to abide by the Code of Ethics and the rules of the AccOT programme, and accumulate a minimum of 60 points over a two-year cycle. Points are allocated to an activity category based on the content and time requirements of each activity. The six domains or categories are (1) OT Practice Development; (2) Private Study; (3) Supervision/Mentoring; (4) Professional Activities; (5) Non Assessed Studies, Courses, Seminars; Assessed Studies, Courses, Seminars; and (6) Research and Publications. Providers are accredited when they present satisfactory records of their continuing professional development to the Association. Of the continuing professional development plans that are provided to the Association, 10% of these are randomly audited. Accreditation is valid for two years.
Physiotherapy

The Australian Physiotherapy Association (APA) Quality Endorsement Programme is an accreditation system established by the Australian Physiotherapy Association in 1990. The Programme is open to all physiotherapy service providers. The APA Quality Endorsement Programme is unique in that it is an accreditation system for practices or departments and not the physiotherapists themselves. Practices or departments are required to meet five standards each with a number of criteria. These standards are (1) Organisation and quality care; (2) Staff management and support; (3) Professional conduct; (4) Facilities and equipment; and (5) Quality management. The practices or departments supply specific documentation with regards to meeting the five standards to the APA.

This documentation is initially reviewed by a panel of physiotherapists before being monitored through a survey process. The survey process involves a trained surveyor (who is a physiotherapist) randomly selecting a practice or department for an on-site audit. All practices or departments are surveyed at least once during their term of accreditation. It is intended by the APA to be able to survey newly accrediting practices / departments within the first six months of their term. The APA Quality Endorsement Programme is run on a four-year cycle. All quality endorsed practices / departments are required to demonstrate continuous quality improvement activities on a yearly basis.

The cost of accreditation with the APA varies according to the membership status of the physiotherapists in the practice or department (excluding temporary locums) It can range from $500 to $3000 for a practice or department to apply for re-accreditation each year. However, for a new application the costs can range from $600 to $3500. Currently there are no practices within this highest cost criterion.
Podiatry

The Australasian Podiatry Council introduced an accreditation system in July, 2000 called “The Accredited Podiatrist Programme”. The system is based on the construction of a Professional Development Plan. A provider is required to undertake a minimum of 30 hours of professional development activities over two years. These activities are divided into five domains of which providers must partake of at least two in their Professional Development Plan to meet the requirements of accreditation. The five domains are (1) Podiatry professional development; (2) Self-directed learning; (3) Podiatrist education; (4) Quality improvement activities and (5) Community service activities. Providers send their Activity Log Sheet to the Australasian Podiatry Council for assessment. Providers are asked to maintain a record of their activities for random auditing procedures conducted by the Australasian Podiatry Council. The Accredited Podiatrist Programme functions on a biannual cycle.

There are no specific costs payable to the Australasian Podiatry Council for accreditation other than a membership fee. The cost of undertaking professional development activities is the responsibility of the provider. Currently, only members of the Council are eligible to participate in the Programme. However, there are plans to introduce a non-members fee and make the Programme available to all providers.

Social Work

The Australian Association of Social Work introduced a “Continuing Professional Education” (CPE) policy in 1997. This accreditation system is based on the maintenance of knowledge through continuing education. The programme is only available to Association members. The social worker must accumulate 200 points over two years. Points are allocated on the basis of activity content and the time required to complete the activity. The activities are divided into four categories with a minimum of 20 points to be gained from the first three categories.
Activity categories are (1) Accountability; (2) Skill development; (3) Gaining new knowledge and information; and (4) Contributing to the development of professional social work knowledge and practice. Applicants need to complete the logbook provided but are not required to provide this with the application for membership renewal. A declaration that CPE requirements have been complied with is necessary for further accreditation. Five percent of providers are randomly selected for audit at some stage during the accreditation cycle. Audited practitioners are required to supply the logbook and relevant documentation to the Association within 28 days. The CPE programme is conducted on a biannual cycle. The Australian Association of Social Work does not receive reimbursement for accrediting providers but the costs associated with gaining points are borne by the provider.

General Comparative Results

The systems of accreditation for each discipline have a number of similarities. Each of them specifies a range of domains for which the provider, practice or department can be held accountable. With the exception of physiotherapy, each discipline requires the provider to establish a professional development plan that includes a range of activities. Each activity must comply with the rules established by the accrediting authority. Professional development plans are also called continuing professional development and continuing professional education.

Despite the use of a wide range of headings for the activities in which providers can become involved, there are three broad themes; continuing education, professional participation and quality assurance. Continuing education includes conference attendance, additional education or training seminars including post-graduate study, publishing and presenting original work, undertaking research and reading discipline specific literature. Professional participation involves non-academic contributions to the profession through membership of relevant boards.
or associations, mentoring other members of the profession and the delivery of community service activities such as public lectures. Quality assurance is a poorly defined area, but includes clinical audit, evaluating patient satisfaction, participating in a trial of a new product and peer review. The APA has the most sophisticated approach to quality assurance at the practice or department level, whereas the other associations emphasize the educational and professional participation aspects of individual providers.

Providers can set their own accreditation outline by selecting from a range of domains or activities to fulfill the requirements of their professional development plan, with the exception of the APA who specifies set domains of accreditation (Table 3). Participation in each activity leads to the accrual of points or hours towards the final accreditation goal. The professional development plans are largely self-directed to cater for different levels of access to training or resources and personal and professional interests. All associations have ensured that rural providers have equitable access to their accreditation systems.

Whilst podiatry, physiotherapy and occupational therapy have endorsed clinical practice guidelines, none of the systems of accreditation makes compulsory the monitoring of adherence to these professionally defined standards. For instance, the APodC has clinical guidelines for foot orthoses prescribed by podiatrists. The Accredited Practicing Podiatrist guide refers specifically to the use of these guidelines as a way to undertake Type 4 activities (quality improvement). However, not every podiatrist being accredited has to undertake type 4 activities. The AccOT manual requires compliance with the Occupational Therapists Code of Ethics for accreditation purposes, which includes adherence to guidelines however these are not explicitly monitored in the accreditation process.

The procedures for monitoring the professional development plans are based on provider self-completion of a log of their activities. The log is submitted to the accrediting body when the appropriate number of points have been achieved, or at a particular period during the
accreditation cycle (except social work which is only monitored through audit). The onus is on the provider to maintain records that verify their participation in an activity, such as receipts for training or notes about a journal article.

The greatest areas of variation in the accreditation systems arise from duration of the accreditation cycle, which varies from one year to four years, and the weighting of the various components of the professional development plans. For instance, a podiatrist must complete a minimum of 30 hours over two years to be accredited. However, a dietitian needs to complete a minimum of 30 hours in one year. Maintaining accreditation requires more time for a dietitian than a podiatrist yet both are given the status of being an “accredited provider”.

Table 3 compares the points obtained for giving a conference presentation, submitting a paper to a peer reviewed journal and reading a journal article or book chapter across the different disciplines. The social work accreditation system awards one point for reading a journal article or a book chapter which provides 0.5% of the total points needed per year (1 point from 200 points. If a podiatrist or dietitian took one hour to read a journal paper, they would accrue 3% or 1/30th of their total points. Identical activities have different values and weightings between associations due to the structure of the accreditation systems.

In addition to the variations in weightings for specific domains of accreditation, the associations (except the APA) allow a degree of flexibility as to the content of the professional development plans. For instance, dietitians can accrue points from any of the domains of accreditation specified by the DAA. The other associations stipulate that the points must come from a variety of domains and set a maximum or minimum number of points or hours that the provider can claim from each area. This means that two providers who are accredited with the same professional association could have achieved their accreditation status in very different ways.
The up-front cost of accreditation to individual providers is relatively low, ranging from the cost of undertaking professional development to obtain accreditation points, to $3500 for non-APA members. The cost of adhering to the professional development plan is borne by the provider, but most associations include a range of options that require little direct financial outlay.

Accreditation systems are promoted to providers on the basis that they receive formal recognition for the maintenance of their skills and that consumers and other stakeholders receive reassurance about the quality of care provided. Also, accreditation systems are intended to see that standards are established which can be recognized by funding bodies (Australasian Podiatry Council 2000; OT Australia 2001; Australian Physiotherapy Association 2000).

*Government funding bodies and third party organizations have proposed a variety of systems for accrediting practitioners – one system, driven by the profession is simpler for individuals and third party organizations (Australasian Podiatry Council 2000:1).*

The tangible benefits to providers are their eligibility to use letters, logos and certificates attesting to their accreditation status. None of the disciplines surveyed reported that accredited providers receive increased reimbursement for their services as a result of their accreditation status.

All of the professional associations have Internet sites that are accessible to the public however the amount of information given to consumers about accreditation of professionals varies greatly. Full information about the accreditation systems is freely accessible on the Internet for occupational therapy, podiatry and social work. The other associations provided general details about accreditation, but the full information was available to members only.
DAA and OT AUSTRALIA actively promote their accreditation system to consumers and other purchasers. Only OT AUSTRALIA lists accredited providers on the Internet.

**Discussion**

The development of accreditation systems by a number of professional associations in Australia has established a firm basis from which debate about the direction of professional self-regulation can proceed.

This comparison has identified three key domains of accreditation that are valued by each professional group, namely continuing education, professional participation and quality assurance. These domains are broadly defined and are subject to a range of inter-disciplinary interpretations. The rewards for adhering to the various components of professional development plans are inconsistent across the disciplines. Additionally, the number of possible combinations of the professional development profiles within each discipline creates the potential for intra-disciplinary variations in the tasks completed to achieve accreditation. Thus, despite general agreement on the domains of accreditation, there is no consensus on the standards that providers must reach to achieve accreditation across the different disciplines.

The variations in accreditation standards means that consumers, purchasers and regulators have no common basis on which they can judge the merits of any of the accreditation systems. Whilst these inconsistencies are of little importance when viewed within the profession, they are likely to create confusion and devalue the entire accreditation approach when examined across disciplines by external audiences, such as patients, purchasers and regulatory bodies.

The current interdisciplinary inconsistencies could be addressed with some relatively minor modifications to the existing systems. The adoption of a common language to describe the domains of accreditation would reduce the confusing array of terms that users and purchasers currently face. The procedures of accreditation could be simplified in three ways. First, by
introducing a standardized time frame for the accreditation cycle. Second, the use of a uniform point scale where the total number of points achieved is consistent across disciplines and the weightings for particular tasks are uniform. Finally, the use of similar systems of monitoring and audit would reduce variations in the level of accountability of each provider.

The advantages of a consistent approach include the attribution of the same meaning to the label of accreditation, regardless of the discipline. This will reduce confusion to patients, and ensure that purchasers who rely on accreditation systems to make funding decisions are basing their decisions on a common definition of accreditation. Providers and associations can use this to their advantage by marketing their accreditation systems to purchasers from a uniform ‘allied health’ platform rather than on the basis of the variable merits of individual systems. This may also give associations the leverage to argue for increased reimbursement for accredited providers jointly, rather than on an association by association basis. Providers currently receive no pecuniary benefits from accreditation, despite the personal and financial outlays required to achieve this status. Additionally, if professional associations adopted similar accreditation systems, they increase the possibilities of pooling resources. For instance, the use of a common, external auditor for monitoring purposes may reduce the resource impost on individual associations, whilst increasing the independence of the assessment.

The disadvantages of adopting a consistent approach are the compromises that each discipline will be forced to make from the systems they have already developed. However, given that the accreditation systems are relatively recent innovations and a large proportion of the allied health population remains to be accredited, this is an ideal time to review the current approaches.

This paper has not debated the content of the accreditation systems adopted by the allied health associations. Accreditation has, in itself, become an institution capable of lending
credibility to a range of individual clinicians or organisations. The broad similarities between the existing models indicate that there is general agreement of the important quality principles within the disciplines. However, as this paper has shown, the internal workings of the accreditation systems adopted by the allied health professions lack clarity and consistency in their approaches. Where the APA emphasizes health service and systems quality the other disciplines focus largely on individual professional development. The accreditation of allied health education has received a great deal of attention over recent years however the accreditation of professionals or practices has not undergone the same level of debate. Few patients or purchasers have been engaged in any discourse about what they value in terms of allied health accreditation systems. Only OT AUSTRALIA reported that they liaised with various consumer and purchaser groups in the development of the AccOT programme. As the patients and purchasers are the end users of the health service and accreditation is their only way of vouching for health service quality, the input of patients and purchasers is vital to ensure that accreditation is a useful, meaningful and accessible concept outside of the professional boundaries. Given that allied health professional accreditation is such a new area, the domains of accreditation require in-depth examination and discussion at a multi-disciplinary level to identify areas that are relevant to all stakeholders and have meaning in the clinical setting. By debating the domains and procedures that underpin accreditation, the disciplines will start to define their own, consistent understanding of health care quality that is specific to allied health.

Consequently, allied health service accreditation would benefit from further research in a number of areas: determining patient and purchaser preferences regarding domains of allied health service quality; examining the needs of the various stakeholders in terms of disseminating information about accreditation systems; and measuring the impact of allied health service provider accreditation on patient outcomes. Additionally, further research and
debate are required to analyse the relative benefits of accrediting practices or departments versus individual providers.

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