HEALTH PROFESSIONS ACCREDITATION COLLABORATIVE FORUM

AUSTRALIAN DENTAL COUNCIL

THE ROLE OF ACCREDITATION IN IMPROVING ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH OUTCOMES

October 2019

THE ROLE OF ACCREDITATION IN IMPROVING ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH OUTCOMES PROJECT

INFOGRAPHIC SUMMARY

THEMATIC REVIEW

218 accredited health practitioner programs

delivered across Australia and/or New Zealand participated in the review.

Representatives across the regulated health professions, including **nursing, dental, occupational therapy, medical, and pharmacy courses** participated in the survey.

CULTURALLY SAFE HEALTH WORKFORCE

92% of respondents said Indigenous Peoples were involved with their programs.

2 in 3 programs have advisors indentifying as Aboriginal and/or Torres Strait Islander, and/or Māori inputting into program design and delivery.

65% have no minimum requirement for students to gain clinical experience in the treatment of Indigenous Peoples.

34% had difficulty in estimating the percentage of students gaining exposure to the treatment of Indigenous Peoples.

In 2018, the Health Professions Accreditation Collaborative Forum (the Forum) undertook *The role of accreditation in improving Aboriginal and Torres Strait Islander health outcomes project*. The project aims to help the Forum better understand the role accreditation plays in improving Aboriginal and Torres Strait Islander and Māori health outcomes and producing a culturally safe workforce.

INDIGENOUS STUDENT SUPPORT

57% use specific entry pathways for Indigenous students.

45% have specific support services in place for Indigenous students at an education provider and program level.

PERCEPTION OF ACCREDITATION

90% of respondents agree the accreditation standard for their program requires graduates to be culturally safe.

60% of respondents believe accreditation has a strong or extensive influence in ensuring the incorporation of cultural safety in curriculum design.

CONTENTS

FOREWORD

What is the role of accreditation in improving Indigenous health outcomes?

At the 2016 National Registration and Accreditation Scheme ('the National Scheme') Combined Meetings, Professor Gregory Phillips challenged participants to ask ourselves what our roles are as actors in the health system in instigating change. Soon after this conference, a project was launched. Collectively, accreditation authorities wanted to know how accredited health practitioner programs in the National Scheme are supporting students identifying as Aboriginal and/or Torres Strait Islander and whether they are producing future health practitioners that are culturally safe.

Through the Health Professions Accreditation Collaborative Forum ('the Forum'), with leadership from the Australian Dental Council (ADC), a baseline survey was designed. As some accreditation authorities also accredit programs delivered in New Zealand, survey questions also asked about Māori in addition to Aboriginal and Torres Strait Islander Peoples.

Over a period of approximately four weeks, all accredited programs in the regulated health professions were asked to complete the survey to assist in understanding the role of accreditation in improving Indigenous health outcomes. The data were analysed and will now inform a collective strategy, involving all accreditation authorities, to use our role in promoting quality education of health practitioners to effect change.

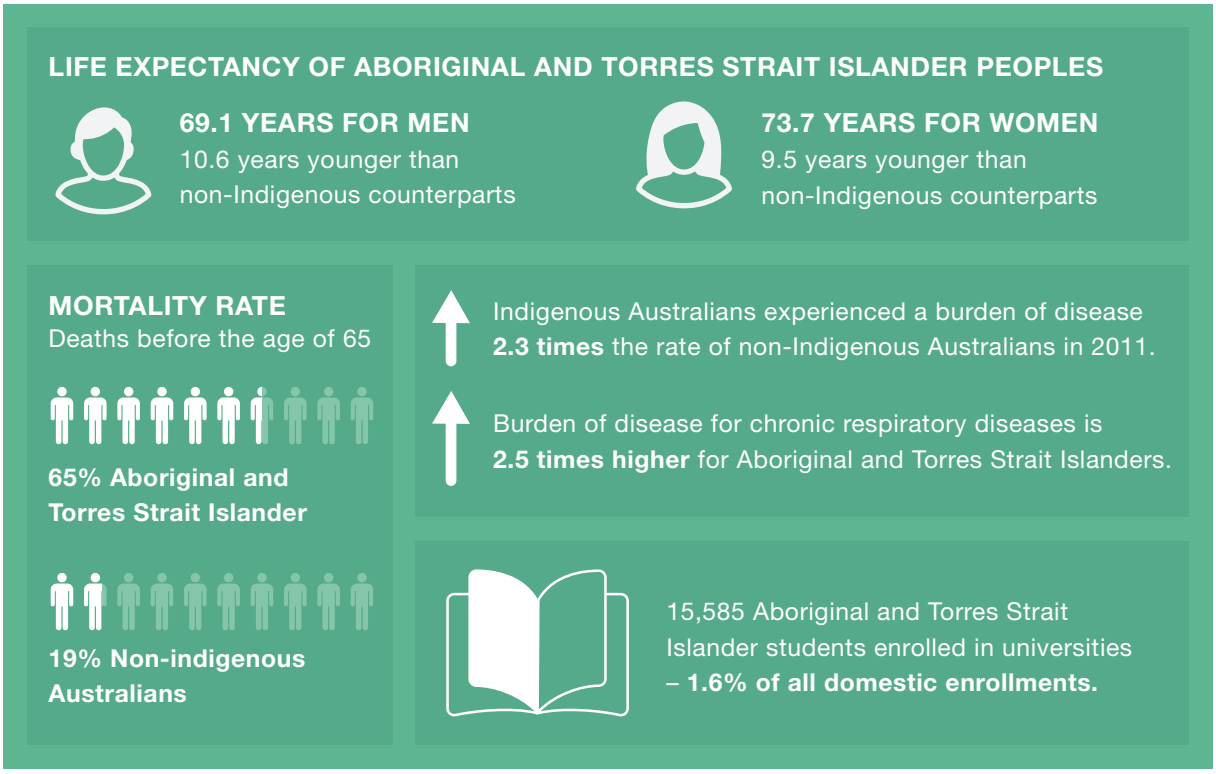
The vast majority of respondents reported that accreditation standards, to varying extents, drive education provider responsiveness in curricula design with respect to cultural safety. This demonstrates the importance of accreditation as a lever for change. There must, however, be a consistent voice regarding specific and explicit reference to the education and training of a culturally safe health workforce for Aboriginal and Torres Strait Islander Peoples. To be a culturally safe practitioner is complex. At the time of writing, the National Scheme Aboriginal and Torres Strait Islander Health Strategy Group ('the Strategy Group') is consulting on a shared definition of cultural safety, as defined by Indigenous Australians, for adoption in the National Scheme. This definition, once agreed, will underpin many of the next steps for entities in the Scheme. Accreditation standards may need to be modified to address cultural safety specifically for Indigenous Australians but will also need to point to the shared understanding of what it is to be culturally safe.

By far, the greatest number of respondents were in the higher education sector reflecting the largest demographic of education provider type in the National Scheme. In Australia, higher education providers are regulated by the Tertiary Education Quality and Standards Agency (TEQSA) against standards which include specific standards for Indigenous students. The extent to which higher education standards or health profession program accreditation standards are the driving factor in curriculum and program design was not explored in the survey.

Most programs reported that they do involve Aboriginal and/or Torres Strait Islander Peoples and/or Māori in their programs but the degree of involvement reported varied.

The survey attracted high response rates in some professions, and relatively low participation in others. This report focuses on the aggregate results, and intends to understand the status quo, where there are opportunities to learn, and to inform the next steps for accreditation systems within the National Scheme regarding our role in improving Indigenous health outcomes. These strategies may include potential revision of accreditation standards; standardised data collection; and development of a shared understanding of good practice in programs and amongst education providers.

Figure 1. Health inequalities in Australia



What is important though is to recognise that accreditation standards and accreditation processes do not work in isolation of the other elements of the Australian health system. Accredited programs can be required to graduate health practitioners with the knowledge, skills and attitudes necessary to deliver culturally safe care. However, the clinical practice environment must also be culturally safe. The Australian Commission on Safety and Quality in Health Care (ACSQHC) revised National Safety and Quality Health Service (NSQHS) Standards (second edition 2018) now include explicit requirements for health services to have regard for six areas for action relating to Aboriginal and Torres Strait Islander Peoples. Ensuring that both health practitioners and the environments in which they work are culturally safe is critical to effecting change.

There is an opportunity for accreditation authorities to demonstrate leadership and work with the education sector, government, other regulators and Indigenous health leaders to further develop a framework for reporting that does not duplicate data already provided elsewhere, but that comprehensively allows accreditation to measure its impact and effectiveness in driving change.

The Forum wishes to acknowledge the participation of all education providers that contributed to the survey. This was a considerable amount of data to report and we now know the differences between the health professions in how these data are, or are not, collected and the extent that they are reportable. The Forum intends to create an action plan for the coming two years, aligned with the work of the Strategy Group, to ensure our collective efforts are concentrated on the areas where we can effect the greatest change.

Narelle Mills
Project Chair
Chief Executive Officer, Australian Dental Council

1. INTRODUCTION

1.1 The Council of Australian Governments (COAG) determined in 2008 to establish a single National Registration and Accreditation Scheme ('National Scheme') for registered health practitioners.

1.2 On 1 July 2010 (18 October for Western Australia), the following professions became nationally regulated under the Health Practitioner Regulation National Law Act 2009 (as in force in each state and territory in Australia; 'the National Law').

- Chiropractors
- Dental practitioners (including dentists, dental hygienists, dental prosthetists, dental therapists and oral health therapists)
- Medical practitioners
- Nurses and midwives
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists.

1.3 On July 2012, four additional professions joined the National Scheme.

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners (including acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers)
- Medical radiation practitioners (including diagnostic radiographers, radiation therapists and nuclear medicine technologists)
- Occupational therapists.

1.4 In December 2018, paramedicine became a regulated health profession in the National Scheme.

1.5 The National Law describes the functions in the National Scheme and the roles and responsibilities along with objectives and guiding principles which guide the way in which the National Law is to be applied. At its simplest level, the functions covered by the National Law are:

- the regulation and registration of individual health practitioners
- accreditation of programs of study leading to eligibility to register
- assessment of competence of overseas qualified practitioners.

1.6 Each regulated health profession has a corresponding National Board that implements the National Scheme. Each National Board must appoint an accreditation authority to undertake the accreditation functions for its profession under the National Law. This may either be an external body or a Committee of the Board. The Australian Health Practitioner Regulation Agency (AHPRA) is the agency that supports the National Boards in implementing the National Scheme.

1.7 The accreditation authorities in the National Scheme at the time of the survey are outlined in Table 1.

Table 1. Accreditation authorities in the National Scheme at the time of the survey

Aboriginal and Torres Strait Islander Health Practice Accreditation Committee	ATSIHPAC
Australian Dental Council	ADC
Australian Medical Council	AMC
Australian Nursing and Midwifery Accreditation Council	ANMAC
Australian Pharmacy Council	APC
Australian Physiotherapy Council	APhysioC
Australian Psychology Accreditation Council	APAC
Australasian Osteopathic Accreditation Council	AOAC
Australian and New Zealand Podiatry Accreditation Council	ANZPAC
Chinese Medicine Accreditation Committee	CMAC
Council on Chiropractic Education Australasia	CCEA
Medical Radiation Practice Accreditation Committee	MRPAC
Optometry Council of Australia and New Zealand	OCANZ
Occupational Therapy Council of Australia	OTC

1.8 In addition to their responsibilities under the National Law, some accreditation authorities also carry out accreditation of programs in New Zealand.

Accreditation under the National Law

1.9 Part 6 of the National Law defines the 'Accreditation functions' exercised by accreditation authorities as follows.

'Accreditation function means:

a) developing accreditation standards for approval by a National Board; or

b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards; or

c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practice the profession in Australia; or

d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this [National] Law and whose qualifications are not approved qualifications for the health profession; or

e) making recommendations and giving advice to a National Board about a matter referred to in paragraph (a), (b), (c) or (d). [1]

1 Please note that not all accreditation authorities are assigned all of these functions.

About the Project

1.10 The Health Professions Accreditation Collaborative Forum ('the Forum') is a coalition of the accreditation authorities in the National Scheme and is funded by its members to pursue cross profession initiatives and best practice in health profession accreditation. In early 2017, the Forum acknowledged there had been little progress across all professions with respect to the health outcomes of Indigenous Australians and committed to better collective understanding of the role of accreditation in improving Aboriginal and Torres Strait Islander health outcomes.

1.11 As part of this commitment, the Forum has agreed to work collaboratively to better understand how accredited health practitioner programs of study affect the health outcomes of Indigenous communities and the role accreditation plays and can play in 'Closing the Gap'.

1.12 'Closing the Gap' is a strategy developed over ten years ago by the Australian government aimed at improving the lives of all Aboriginal and Torres Strait Islander Peoples by delivering better health, education and employment outcomes. 'Closing the Gap' marked a new approach to achieving equity in health status and life expectancy between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians. Although the strategy commenced over ten years ago, the gap still remains. The Aboriginal and Torres Strait Islander population have, on average, 2.3 times the disease burden of non-Indigenous Australians. For example, there are differences in life expectancy with non-Indigenous Australians living longer (10.6 years longer for males and 9.5 years for females), and in rates of child mortality (Indigenous children die at more than twice the rate of non-Indigenous children). A range of factors contribute to differences in health needs across the community including the social determinants of health, access to timely and appropriate health services, health behaviours, and intergenerational trauma. By setting the standards for education and training of health practitioners, accreditation can contribute to developing practitioners with the skills and knowledge to protect and advance the health and wellbeing of all Australians — individual patients, communities and populations.

1.13 To achieve this, the Forum established the *Role of accreditation in improving Aboriginal and Torres Strait Islander health outcomes project*. The project involved a thematic review to gather baseline data across accredited health practitioner programs in Australia and programs accredited by accreditation authorities in New Zealand.

1.14 As the survey also included some programs delivered in New Zealand, the survey questions also asked about Māori in addition to Aboriginal and Torres Strait Islander Peoples.

1.15 The project aimed to inform the next steps for accreditation authorities in improving health outcomes for Aboriginal and Torres Strait Islander Peoples by capturing the extent to which health practitioner programs are supporting students identifying as Aboriginal and/or Torres Strait Islander and producing future health practitioners with the knowledge, skills and attitudes necessary to deliver culturally safe care.

Extract from National Scheme Aboriginal and Torres Strait Islander Health Strategy, Statement of Intent (June 2018)

1.16 A working group was established to oversee the project. The working group included the following membership.

Narelle Mills
Chief Executive Officer, Australian Dental Council (Chair)

Theanne Walters
Deputy Chief Executive Officer, Australian Medical Council

Michael Shobbrook
Director, Council on Chiropractic Education Australasia

Elaine Duffy
Chair, Aboriginal and Torres Strait Islander Health Practice Accreditation Committee

Shane Patman
Chair, Australian Physiotherapy Council

Michael Guthrie
Director, Accreditation and Quality Assurance, Australian Dental Council.

1.17 Some initial project support was provided to the working group by the AHPRA Joint Project and Policy Officer, Vanessa Oelkers.

Concurrent work in the National Scheme

1.18 Concurrent with this work, AHPRA established the National Scheme Aboriginal and Torres Strait Islander Health Strategy Group ('the Strategy Group') which includes Aboriginal and Torres Strait Islander health leaders, National Boards, consumer representatives and accreditation authorities. The first milestone outcome of the Strategy Group culminated in the publication of the Statement of Intent in June 2018. The Statement of Intent was signed by over 30 bodies within and external to the National Scheme. It articulates the commitment of the signatories to be responsive to the inequity in health outcomes between Indigenous and non-Indigenous Australians, setting out an intent to 'work together to achieve equity in health outcomes between Aboriginal and Torres Strait Islander Peoples and other Australians to close the gap by 2031'. [2]

2 https://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/Statement-of-intent.aspx (accessed 2 April 2019)

'We commit, using our leadership and influence, to realising our vision including through our application of the National Law to ensure:

- *a culturally safe health workforce supported by nationally consistent standards, codes and guidelines across all professions in the National Scheme*
- *using our leadership and influence to achieve reciprocal goals*
- *increased Aboriginal and Torres Strait Islander Peoples' participation in the registered health workforce*
- *greater access for Aboriginal and Torres Strait Islander Peoples to culturally safe services of health professions regulated under the National Scheme, and*
- *increased participation across all levels of the National Scheme.'*

2. METHODOLOGY

About the survey

2.1 The survey was developed by the working group with input from other accreditation authorities and the Strategy Group. The survey was piloted with a small sample of education providers and adjustments were made based on their feedback on usability and a preliminary analysis of the quality of the data provided. The survey received ethics approval from the Human Research Ethics Committee of The University of Notre Dame Australia (Reference: 018073F).

2.2 The survey was delivered using an online survey tool. The Australian Dental Council (ADC) funded and administered the survey on behalf of the Forum using a third-party survey provider, 'Truth Serum'.

2.3 Invitations to participate in the survey, including follow-up reminders, were sent by each individual accreditation authority to education providers delivering the programs they accredit.

2.4 The survey period was from 13 June 2018 to 18 July 2018.

Analysis of survey data

2.5 The survey questions are included in full in Appendix 1. The survey comprised a combination of closed questions where respondents were asked to select from a pre-defined list; open questions which asked for specific items of quantitative data; and open questions which allowed for free-text responses. Survey design enabled specific additional or contextual questions to be asked dependent on the response to a previous question.

2.6 Initial reporting of quantitative data was undertaken by Truth Serum with further quantitative and qualitative analysis of data undertaken by the ADC on behalf of the Forum and in consultation with the working group.

2.7 Qualitative data were analysed to identify recurrent themes using an approach consistent with the thematic analysis methodology outlined by Braun and Clarke (2006). [1]

Limitations

2.8 In the reporting of survey data that follows, we have been mindful of the limitations of the survey design and administration and the quality of the data reported by participants. We have avoided generalising the survey findings to the wider population of accredited programs and professions that did not provide data or provided limited data.

2.9 The following outlines the limitations of the survey and survey data.

- Some, but not all, accreditation authorities have arrangements to accredit programs delivered in New Zealand. The means of distributing the survey meant that a small amount of data were collected from New Zealand education providers for programs which are not accredited by an accreditation authority.
- The data include some known duplicate entries and/or data entry errors by survey participants. This has the effect of overstating the number of responses and the number of programs reporting data.

1 Braun, V. and Clarke, V (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), pp.77–101.

- The number of accredited programs varies between professions. For some professions only a small amount of data was collected. This limits the applicability of the findings across all accreditation authorities.
- Identifying as Aboriginal and/or Torres Strait Islander is a requirement for entry into programs leading to eligibility to register in the Aboriginal and Torres Strait Islander health practice profession. Some survey questions therefore apply differently to this group for whom the involvement of Aboriginal and Torres Strait Islander Peoples is inherent in the scope of the profession. Inclusion of data from this profession may have the effect of overstating some aggregate data items.
- The number of accredited programs in the National Scheme at the time of the survey were provided to the working group by each accreditation authority. The structure of education and training for each profession and the scope of responsibilities for each accreditation authority varies. How and what each accreditation authority counts as an accredited program may therefore also vary.
- Most data have been reported at the aggregate level as it was considered to be the most meaningful level of analysis, particularly taking into account the small amount of data collected for some professions and for some other variables. However, aggregate data may obscure important differences in some areas, for example, differences between qualifying and specialist education and training in some professions.
- Each individual accreditation authority was responsible for sending out invitations and reminders to participate for the programs they accredit. The number of reminders may have varied between accreditation authorities, which may have led to different response rates.
- In designing the survey to maximise the number of responses, the survey could be completed for a number of programs across a provider, or by a specific accredited program. This resulted in some programs appearing to be represented in education provider wide responses as well as in standalone responses.

Key to tables

- **Number of programs responding** or **Sample** gives the total number of respondents or programs providing a response / data. This figure may include duplicate or erroneous entries and responses related to programs in New Zealand which are not accredited by an accreditation authority under the National Scheme.
- **Number of accredited programs** gives the number of programs accredited by the respective accreditation authority at the time of the survey. This is the number of programs that were contacted and asked to participate in the survey. This may not include the full range of programs accredited by each authority.
- **Number of accredited programs responding** in Table 4 gives the number of programs recorded as having responded to the survey, with the following removed where identified.
  - duplicate entries
  - erroneous entries
  - entries relating to programs that are not accredited by an accreditation authority.

3. SURVEY FINDINGS

3.1 This section outlines the findings from the survey. The majority of data are reported on an aggregate, multi-profession basis, with data broken down by profession or other important variables where helpful.

3.2 An overview of the profile of responses is provided below. The analysis has then been structured around the key areas addressed in the survey questions. The figures reported in tables and graphs use the raw data collected in the survey unless otherwise stated.

Responses to the survey

3.3 112 responses were made to the survey. Sixty seven per cent, the majority of responses, were from universities or other self-accrediting higher education providers (Table 2).

Table 2. Number of responses by type of education provider

Type of education provider	%	Sample (responses)
University or other self-accrediting higher education provider	67%	75
Vocational Education and Training provider	14%	16
Specialist college	13%	15
Private higher or further education provider, non-self-accrediting	3%	3
Aboriginal Community Controlled Health Organisation	2%	2
Aboriginal Health College	0%	0
Wānanga New Zealand specific	0%	0
Other (please specify)	1%	1
Total		**112**

Note: 'Other' said they were a non-university education provider

3.4 The survey gathered data on 218 accredited health practitioner programs delivered across Australia and New Zealand. Data were collected for at least one program for each of the 14 professions included in the National Scheme at the time of the survey. The overall response rate was 20% (Table 3).

3.5 To provide a more accurate picture of the response rate, the data were reviewed to identify responses which were obviously duplicative (e.g. the same program responding twice); erroneous (e.g. an education provider selecting in error a specialty in which they do not deliver an accredited program); or relate to a program not accredited by an accreditation authority (e.g. for some authorities, a program delivered in New Zealand). All such responses may not have been identified. Removing these responses, the number of accredited programs responding was 188, a response rate of 18% (Table 4).

Table 3. Number of responses by profession and program

Profession	Number of accredited programs	% of total accredited programs	Number of programs responding	% sample	% response
Aboriginal and Torres Strait Islander Health Practice	14	1.3%	9	4%	64%
Chinese Medicine	9	0.8%	2	0.9%	22%
Chiropractic	5	0.5%	5	2%	100%
Dental	62	6%	67	31%	108%
Medical	127	12%	35	16%	28%
Medical Radiation Practice	25	2%	4	2%	16%
Nursing and Midwifery	192	18%	37	17%	19%
Occupational therapy	62	6%	11	5%	18%
Optometry	7	0.7%	5	2%	71%
Osteopathy	6	0.6%	1	0.5%	17%
Pharmacy	20	2%	11	5%	55%
Physiotherapy	54	5%	17	8%	31%
Podiatry	19	2%	1	0.5%	5%
Psychology	465	43%	13	6%	3%
Total	**1,067**		**218**		**20%**

Table 4. Number of responses by profession and program — with known duplicates and erroneous entries removed

Profession	Number of accredited programs	Number of accredited programs responding	% of accredited programs responding
Aboriginal and Torres Strait Islander Health Practice	14	8	57%
Chinese Medicine	9	2	22%
Chiropractic	5	5	100%
Dental	62	47	75%
Medical	127	31	24%
Medical Radiation Practice	25	3	12%
Nursing and Midwifery	192	36	19%
Occupational therapy	62	10	16%
Optometry	7	5	71%
Osteopathy	6	1	17%
Pharmacy	20	11	55%
Physiotherapy	54	15	28%
Podiatry	19	1	5%
Psychology	465	13	3%
Total	**1,067**	**188**	**18%**

3.6 Of the responses collected, the majority, 87%, were received from education providers delivering programs in Australia only (Figure 2).

Figure 2. Responses by country of delivery

AUSTRALIA

87%

BOTH AUSTRALIA AND NZ

10%

NEW ZEALAND

3%

Note: The 1% of respondents selecting 'other' indicated that the program was also delivered in Hong Kong, Singapore and Malaysia.

Professional competencies and learning outcomes

3.7 Of the programs providing data, the majority, 79%, reported that the relevant professional competencies articulated requirements to respectfully treat, work with, and understand, patients who identify as Aboriginal and/or Torres Strait Islander and/or Māori (Figure 3).

3.8 Seventy six per cent of programs that provided data in response to the relevant question said that they had mapped program outcomes to the list of professional competencies (Table 5).

Figure 3. Agreement as to whether the professional competencies expected at the point of graduation articulate the requirements to respectfully treat, work with, and understand patients who identify as Aboriginal and/or Torres Strait Islander (for Australian programs) and/or Māori (for New Zealand programs)

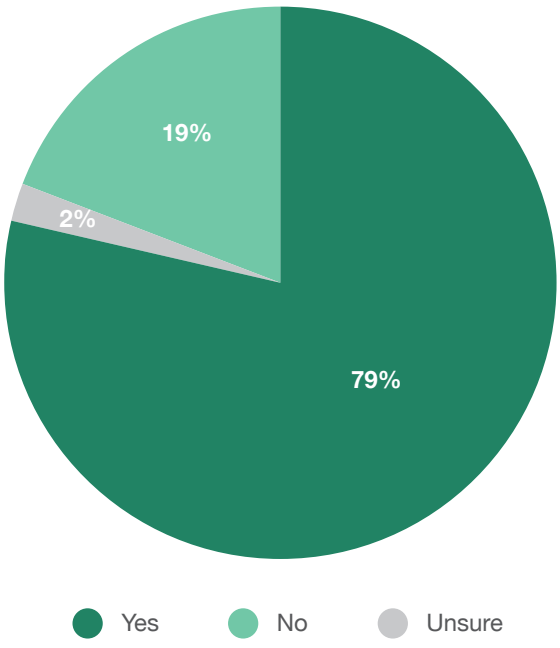


Table 5. Alignment of learning outcomes and requirements to respectfully treat, work with, and understand patients who identify as Aboriginal and/or Torres Strait Islander (for Australian programs) — by program

Answer	%	Sample (programs)
Program outcomes are mapped to the list of competencies	76%	141
The program sets additional competencies	8%	15
The program has adopted another list of competencies for this requirement	4%	8
Other	12%	22
Total		**186**

Involvement of Aboriginal and/or Torres Strait Islander Peoples and/or Māori in programs

3.9 The majority of respondents, 92%, reported that Aboriginal and/or Torres Strait Islander Peoples and/or Māori were involved in some way in their programs (Figure 4).

3.10 The data indicates that levels of involvement are high amongst all education provider types (Table 6).

Figure 4. Involvement of Aboriginal and/or Torres Strait Islander Peoples and/or Māori in programs

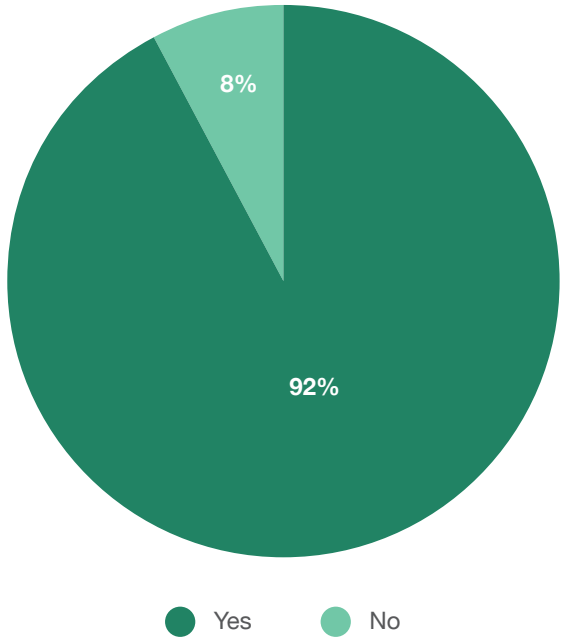


Table 6. Involvement of Aboriginal and/or Torres Strait Islander Peoples and/or Māori in programs — by type of education provider

Type of education provider	Yes	% of education provider type	No	% of education provider type
University or other self-accrediting higher education provider	69	93%	5	7%
Vocational Education and Training provider	14	88%	2	13%
Specialist college	13	87%	2	13%
Private higher or further provider, non-self-accrediting	3	100%	0	0%
Aboriginal Community Controlled Health Organisation	2	100%	0	0
Aboriginal Health College	0	0	0	0
Wānanga New Zealand specific	0	0	0	0
Other (please specify)	1	0	0	0
Total	**102**		**9**	

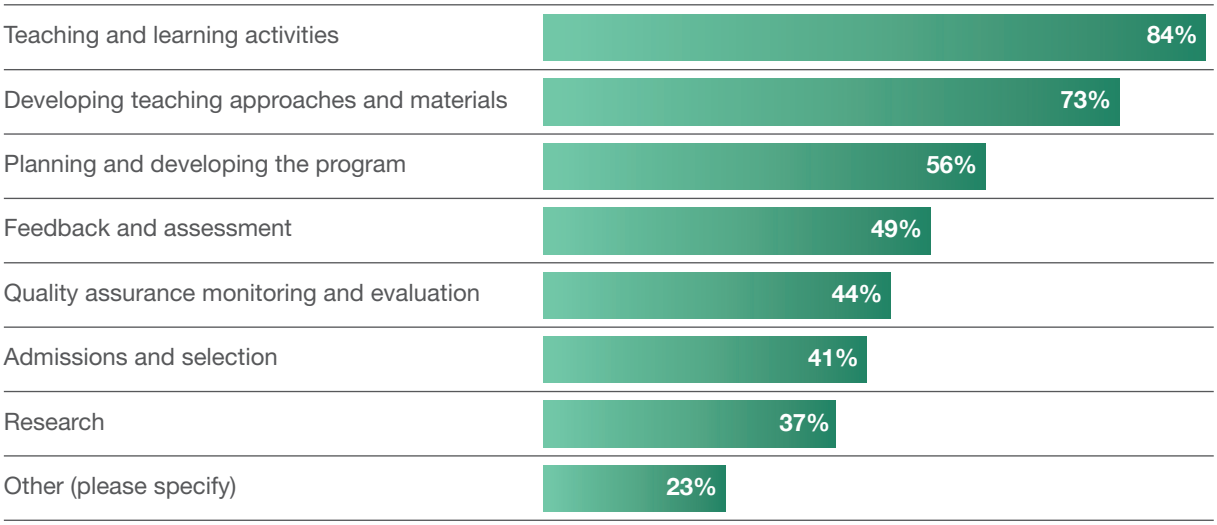
3.11 There was no significant variation in the involvement of Aboriginal and/or Torres Strait Islander Peoples and/or Māori on the basis of profession (Table 7).

3.12 Aboriginal and Torres Strait Islander Peoples and Māori are involved across a variety of areas across program design and delivery. This involvement was primarily in teaching and learning activities (84%) and in developing teaching approaches and materials (73%). Aboriginal and Torres Strait Islander Peoples and Māori were relatively less involved in research (37%) and admission and selection (41%) (Figure 5).

Table 7. Involvement of Aboriginal and Torres Strait Islander Peoples and Māori in programs — by profession and program

Profession	Yes (%)	No (%)	Sample (programs)
Aboriginal and Torres Strait Islander Health Practice	100%	0%	9
Chinese Medicine	100%	0%	2
Chiropractic	100%	0%	5
Dental	85%	15%	67
Medical	91%	9%	35
Medical Radiation Practice	100%	0%	4
Nursing and Midwifery	95%	5%	37
Occupational therapy	100%	0%	11
Optometry	100%	0%	5
Osteopathy	100%	0%	1
Pharmacy	90%	10%	10
Physiotherapy	94%	6%	17
Podiatry	100%	0%	1
Psychology	100%	0%	13
Total			**217**

Figure 5. Involvement of Aboriginal and/or Torres Strait Islander Peoples and/or Māori in programs — by type of involvement



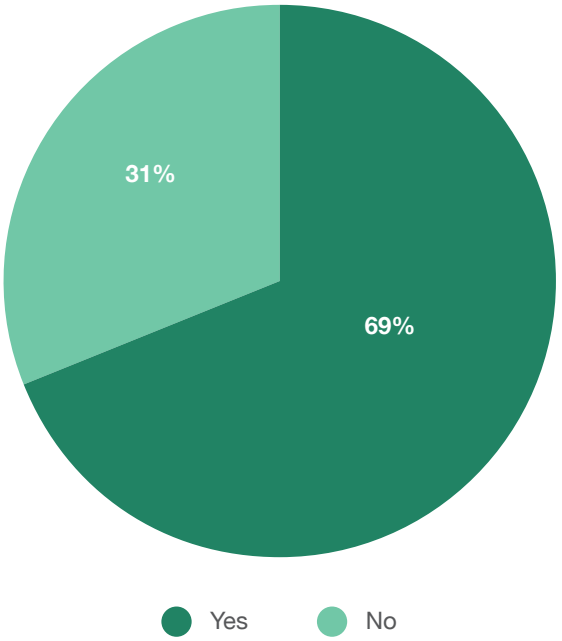
Note: Respondents could select multiple types

3.13 Where respondents chose 'other', they said they involved Indigenous Peoples through or in one or more of the following.

- Consultation
- Mentoring
- Staff Training
- Communication and engagement
- Clinical placements
- Committees and reference groups.

3.14 Sixty nine per cent of respondents reported that they had an advisor who identifies as Aboriginal and/or Torres Strait Islander and/or Māori (Figure 6).

Figure 6. Education providers that have an advisor who identifies as Aboriginal and/or Torres Strait Islander and/or Māori and who has input into the design and/or delivery of programs



3.15 The engagement of an advisor varied between education provider types, with Vocational Education and Training (VET) providers and specialist colleges more likely to report that they did not engage such an advisor than higher education providers. Just 50% of Aboriginal Community Controlled Health Organisations reported that they engaged such an advisor but the sample is small. The nature of the Aboriginal and Torres Strait Islander health practice profession means that the staffing complement for programs will include a high number of people who identify as Aboriginal and/or Torres Strait Islander (Table 8).

3.16 The seniority of the advisor varied in responses, with examples given of professorial, director, associate dean and senior lecturer level appointments. A number of responses noted the appointment of senior staff with responsibility for Indigenous matters across the education provider.

3.17 The term 'advisor' may have been unclear. Some respondents noted that they did not have a specific individual or individuals (as inferred in the language of 'advisor') but a committee with participation from Indigenous Peoples including Indigenous trainees. This appeared to be particularly the case for programs delivered by professional colleges.

Table 8. Education providers that have an advisor who identifies as Aboriginal and/or Torres Strait Islander, and/or Māori and who has input into the design and/or delivery of programs — by type of education provider

Type of education provider	Yes	% of education provider type	No	% of education provider type
University or other self-accrediting higher education provider	54	72%	21	28%
Vocational Education and Training provider	9	56%	7	44%
Specialist college	9	60%	6	40%
Private higher or further provider, non-self-accrediting	3	100%	0	
Aboriginal Community Controlled Health Organisation	1	50%	1	50%
Aboriginal Health College	0	0%	0	0%
Wānanga New Zealand specific	0	0%	0	0%
Other (please specify)	1	100%	0	0%
Total	**77**		**35**	

Cultural competence and cultural safety

3.18 Fifty per cent of respondents reported that cultural competence and cultural safety were considered different terms in their programs, with different outcomes. However, 36% reported that they either did not differentiate between the terms or that they were unsure (Figure 7).

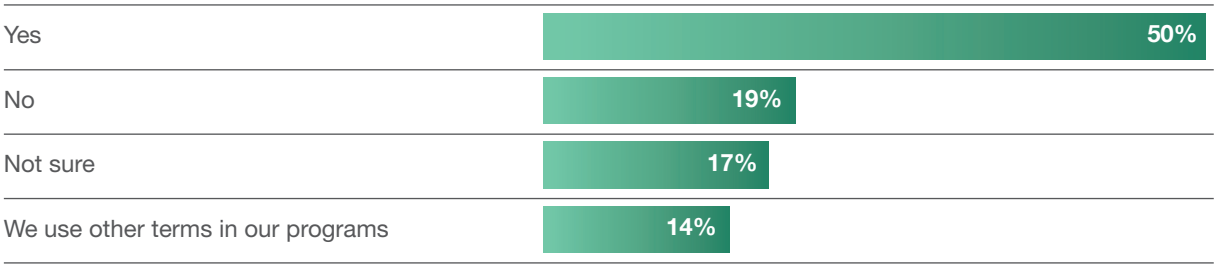
3.19 Where education providers reported that alternate terminology was used in their programs, terminology included the following.

- cultural awareness
- cultural responsiveness
- cultural capability
- cultural security
- cultural contexts.

3.20 Respondents were asked to provide information about the profession-specific learning outcomes for cultural safety and/or cultural competence used in their programs. Some responses indicated that 'cultural safety' was used specifically in relation to understanding the historical, social and cultural contexts of Aboriginal and/or Torres Strait Islander Peoples and/or Māori in order to meet their healthcare needs, with 'cultural competence' used to describe the understanding and skills required to work sensitively with a broader range of culturally and linguistically diverse communities. However, overall, the responses indicate that differences in the outcomes ascribed to these terms cannot be easily characterised. The terms were often used interchangeably, with considerable overlap in the learning outcomes described.

3.21 The following provides some examples of learning outcomes described by respondents and whether they said they were related to cultural safety, cultural competence or 'other'.

Figure 7. Differentiation between cultural competence and cultural safety



Cultural safety and cultural competence — Examples of learning outcomes

Cultural safety

‘Apply the principles of cultural safety to enable culturally sensitive care to be applied across a range of populations and health care settings, but with particular reference to socially and culturally marginalised populations.’

‘Understanding of Aboriginal and Torres Strait Islander history and its impacts on individual and community social and emotional wellbeing. Recognition of racism and its impacts on people. Identification of structural racism and how it impacts on service efficacy and engagement.’

Cultural competence

‘Practice in ways that show a commitment to social justice and the processes of reconciliation based on understanding the culture, experiences, histories and contemporary issues of indigenous Australian communities.’

‘Understand and describe the factors that contribute to the health and wellbeing of Aboriginal and Torres Strait Islander Peoples and/or Māori, including history, spirituality and relationship to land, diversity of cultures and communities, epidemiology, social and political determinants of health and health experiences.’

Other

‘Graduates will demonstrate awareness of the determinants of health or diverse populations, including Aboriginal and Torres Strait Islander Peoples and other disadvantaged populations, and provide socially and culturally responsive healthcare.’

‘Plan and implement an efficient, effective, culturally responsive and client-centred physiotherapy assessment, engage in an inclusive, collaborative, consultive [sic], culturally responsive and client-centred model of practice.’

Teaching, learning and assessment

3.22 The survey data indicate that a rich variety of different types of teaching and learning activities are used for cultural competence and/or cultural safety curriculum elements in programs.

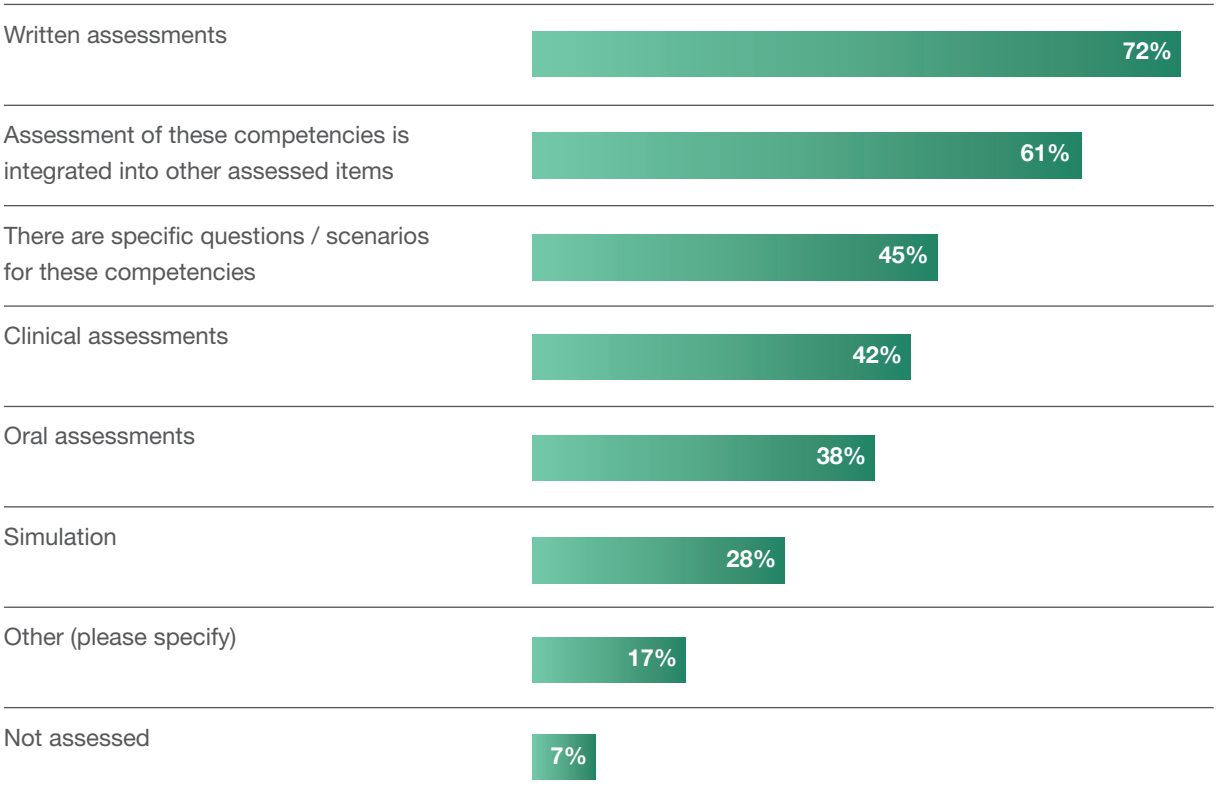
3.23 Types of activity frequently cited included lectures, tutorials, workshops and clinical experience. Examples were given of activities delivered through problem-based learning, role play, simulation and through a variety of different media including online content.

3.24 There is a wide variety of ways in which cultural competence and/or cultural safety is assessed in programs. Ninety three per cent of respondents said their programs assessed these areas. These areas are most commonly assessed through written assessments (72%) and least assessed through simulation (28%). A significant proportion of respondents, 61%, said that they integrated assessment of these competencies in other assessments (Figure 8).

3.25 Where respondents chose 'other', examples of assessment types included the following.

- reflective journals and portfolios
- multiple choice questions
- project work
- case studies
- online quizzes.

Figure 8. Assessment of cultural competence and/or cultural safety



Note: Respondents could choose multiple types

Clinical experiences

3.26 Sixty five per cent of respondents reported they did not have minimum requirements for students to have clinical experiences providing care to Aboriginal and/or Torres Strait Islander Peoples and/or Māori or working with their communities (Table 9).

3.27 Forty two per cent of respondents overall did not provide any answer to the question on this topic. Where a response was made, 34% reported that they had difficultly estimating the percentage of students gaining such experiences or did not collect this data (Table 10).

Table 9. Minimum requirements for clinical experiences

Type of clinical experience	%	Sample (respondents)
Aboriginal and Torres Strait Islander persons and/or Māori as patients or clients only	16%	17
Aboriginal and Torres Strait Islander and/or communities only	1%	1
Aboriginal and Torres Strait Islander Persons and/or Māori as patients or clients or Aboriginal and Torres Strait Islander and/or Māori communities	18%	20
No minimum requirement is specified for either treatment of Aboriginal and Torres Strait Islander persons and/or Māori as patients or clients, or Aboriginal and Torres Strait Islander and/or Māori communities	65%	71
Total		**109**

Table 10. Percentage of students normally gaining clinical exposure

Range	%	Sample (respondents)
Less than 10%	12%	8
10–25%	15%	10
26–49%	12%	8
50–79%	6%	4
80–100%	20%	13
Do not track / hard to know / data not collected	34%	22
Total		**65**

3.28 The qualitative data show that although the majority of education providers do not have minimum requirements in place, most students are expected to gain some exposure to providing care to Aboriginal and/or Torres Strait Islander Peoples and/or Māori during their programs.

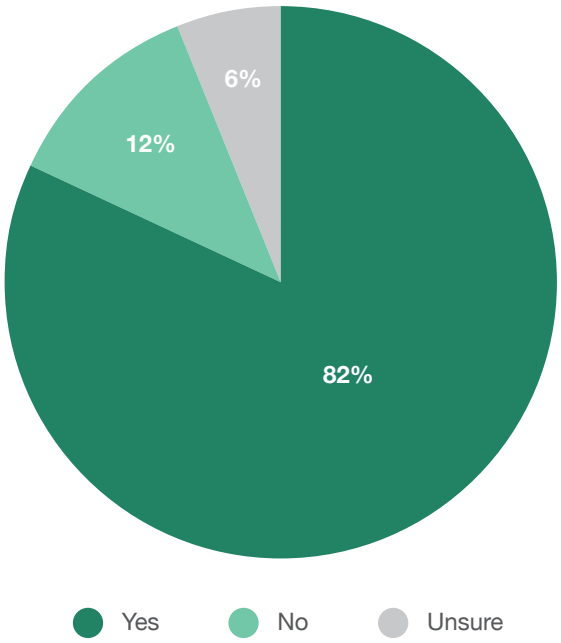
3.29 Views about whether it was feasible for all students to gain such clinical experience varied. Some education providers commented that they had achieved this through relationships with Aboriginal health services or through clinical outplacements in rural or remote areas, whilst acknowledging that this may not be practicable in other areas. Others described how they could not guarantee that each and every student would have experience of providing care to Indigenous persons. The following reasons were given.

- It is impossible to predict the patient-mix of health services providing clinical placements.
- Low numbers of Indigenous Peoples relative to student numbers in some geographic locations.
- The nature of the profession or specialty, for example, pathology.
- Insufficient numbers of clinical placements.
- Burden is placed on a limited number of service providers, with additional investment required to ensure liaison and coordination of placements.

Curriculum design

3.30 The majority of respondents were aware of the Aboriginal and Torres Strait Islander Health Curriculum Framework ('the National Framework')[1] (Figure 9).

Figure 9. Awareness of the Aboriginal and Torres Strait Islander Health Curriculum Framework (2016)



3.31 Fifty nine per cent said they used the National Framework either on its own or with other frameworks to inform curriculum design (Table 11).

1 Department of Health (2016). Aboriginal and Torres Strait Islander Health Curriculum Framework. https://www.health.gov.au/internet/main/publishing.nsf/Content/72C7E23E1BD5E9CFCA257F640082CD48/$File/Health%20Curriculum%20Framework.pdf

Table 11. Use of the Aboriginal and Torres Strait Islander Health Curriculum Framework (2016) and/or other frameworks

Answer	%	Sample (respondents)
We use the Aboriginal and Torres Strait Islander Health Curriculum Framework to inform our curriculum design	26%	27
We use both the Aboriginal and Torres Strait Islander Health Curriculum Framework and other Frameworks to inform our curriculum design	33%	34
We do not use the Aboriginal and Torres Strait Islander Health Curriculum Framework although we do use other Frameworks to inform our curriculum design	26%	27
We use neither the Aboriginal and Torres Strait Islander Health Curriculum Framework nor any other Frameworks to inform our curriculum design	13%	13
We are a New Zealand Program of Study	3%	3
Total		**104**

3.32 Where the National Framework was used, respondents reported that they had used it as a reference tool to inform curriculum design and delivery. It was often reported that they used the entirety of the National Framework and had adopted, or were adopting, its wording. Examples given of the use of specific aspects of the National Framework included the following.

- The graduate cultural capability model (novice, intermediate, entry to practice) has been used to design teaching components, to map capabilities across programs and identify gaps.
- The National Framework has been used to inform discussion about themes such as white privilege, racism, cultural safety and cultural humility.
- The National Framework has been used to advocate for work within an education provider including training and to support the creation of Indigenous working groups at school and faculty level.

3.33 The 'other' frameworks used in curriculum design referenced by respondents included the following.

- Professional competencies and Accreditation Standards published by accreditation authorities and/or national boards.
- Policies or frameworks in place at specific institutions including Indigenous strategy documents and reconciliation action plans.
- National policy documents including the Australian Government's 'Closing the Gap' plan.
- Profession or discipline specific frameworks including the National Aboriginal and Torres Strait Islander Public Health Curriculum Framework 2nd Edition (Public Health Indigenous Leadership in Education Network 2017) and the Indigenous Health Curriculum Framework (Committee of Deans of Australian Medical Schools 2004).

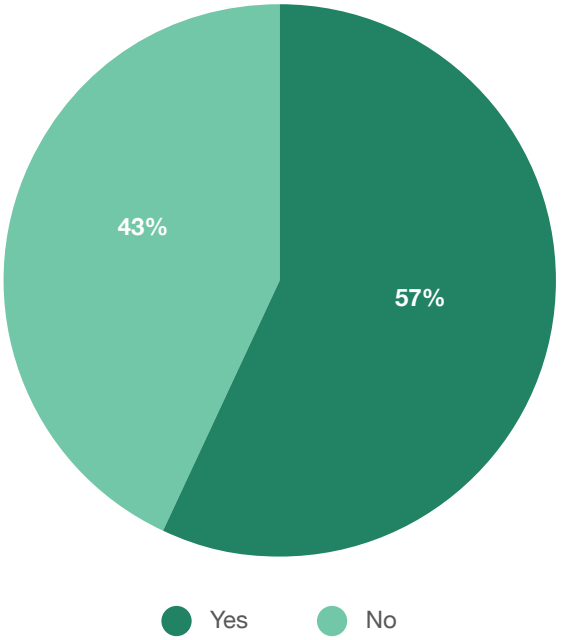
3.34 Where respondents said that they did not use the National Framework to inform curriculum design, they gave the following reasons.

- Lack of awareness of the National Framework.
- The National Framework was considered to lack relevance to specific professions, specialties or levels of education.
- Use instead of other profession or institution specific frameworks, the content of which may or may not have been influenced by the National Framework. Some expressed a preference for profession-specific frameworks.
- The length, level of detail and complexity of the National Framework.
- A small number of VET providers explained that they did not use the National Framework because they were required to deliver industry determined training packages.

Entry pathways and student support

3.35 Fifty seven per cent of respondents reported that they had specific entry pathways to encourage the participation of Aboriginal and/or Torres Strait Islander and/or Māori students (Figure 10).

Figure 10. Specific entry pathways for Aboriginal and/or Torres Strait Islander and/or Māori students



3.36 There was significant variation between different types of education provider as to whether specific entry pathways were in place. Seventy per cent of self-accrediting higher education providers reported specific entry pathways compared to 50% of VET providers and 20% of specialist colleges. The response from Aboriginal Community Controlled Health Organisations reflects that identifying as Aboriginal and/or Torres Strait Islander is an entry requirement for programs in the Aboriginal and Torres Strait Islander health practice profession (Table 12).

Table 12. Specific entry pathways for Aboriginal and/or Torres Strait Islander and/or Māori students — by type of education provider

Type of education provider	Yes	% of education provider type	No	% of education provider type
University or other self-accrediting higher education provider	51	70%	22	30%
Vocational Education and Training provider	8	50%	8	50%
Specialist college	3	20%	12	80%
Private higher or further provider, non-self-accrediting	1	33%	2	67%
Aboriginal Community Controlled Health Organisation	0	0%	2	100%
Aboriginal Health College	0	0%	0	0%
Wānanga New Zealand specific	0	0%	0	0%
Other (please specify)	0	0%	1	100%
Total	**63**		**47**	

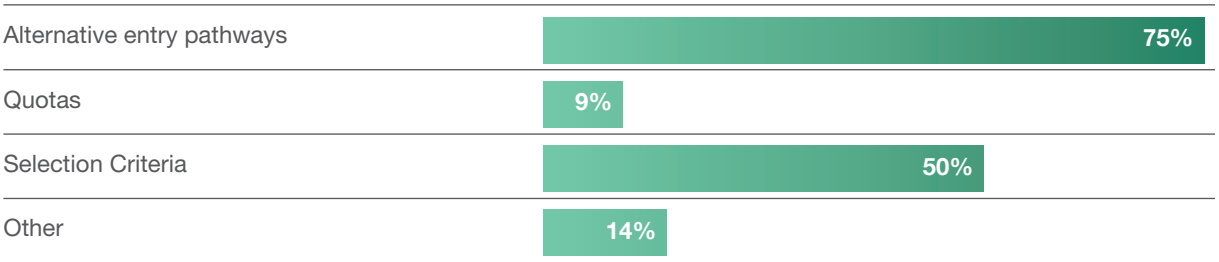
3.37 The most common pathways indicated by respondents were alternative entry pathways and selection criteria (Figure 11). Forty eight per cent of the total number of responses to the survey did not provide any data about specific entry pathways.

3.38 The mechanism used most frequently by education providers to identify potential students who identify as Aboriginal and/or Torres Strait Islander and/or Māori was self-disclosure during application for admission.

3.39 Self-disclosure of students was supported through specific activities aimed at increasing participation of Indigenous Peoples in programs including through the following.

- Outreach programs, such as visits to high schools to encourage applications and open days to provide more information about programs.
- Alternative access pathways and university preparatory programs.
- Dedicated support services for students.

Figure 11. Types of entry pathways into accredited programs for Aboriginal and/or Torres Strait Islander, and/or Māori students



3.40 A small number of respondents reported that their education provider did not allow them access to admissions data which would enable them to identify Aboriginal and/or Torres Strait Islander and/or Māori students.

3.41 The majority of respondents, 92%, said their programs and/or institutions had specific support services in place for Aboriginal and/or Torres Strait Islander and/or Māori students. (Figure 12).

3.42 There was some variation in whether specific support services are in place based on the type of education provider. Sixty per cent of specialist colleges reported such services were in place compared to 96% of self-accrediting higher education providers and 100% of VET providers (Table 13).

Figure 12. Specific support services for Aboriginal and/or Torres Strait Islander and/or Māori students

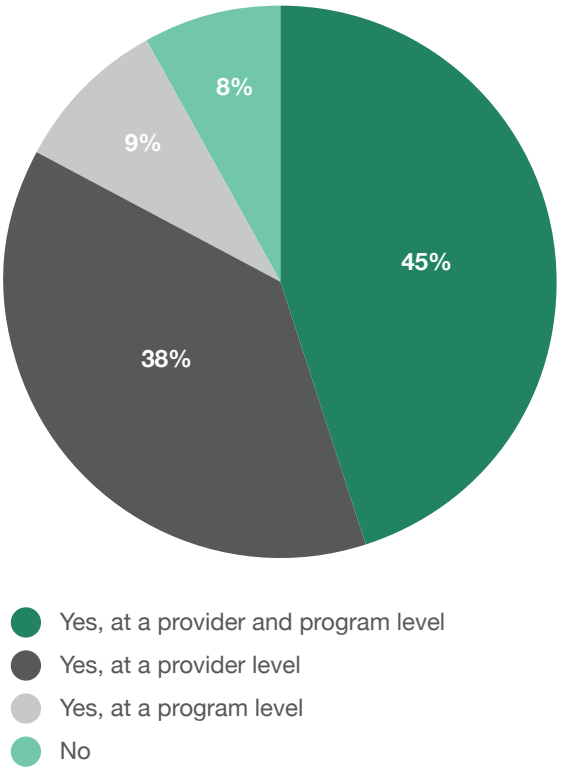


Table 13. Specific support services for Aboriginal and/or Torres Strait Islander and/or Māori students — by type of education provider

Type of education provider	Yes	% of education provider type	No	% education provider type
University or other self-accrediting higher education provider	69	96%	3	4%
Vocational Education and Training provider	16	100%	0	0%
Specialist college	9	60%	6	40%
Private higher or further provider, non-self-accrediting	3	100%	0	0%
Aboriginal Community Controlled Health Organisation	2	100%	0	0%
Aboriginal Health College	0	0%	0	0%
Wānanga New Zealand specific	0	0%	0	0
Other (please specify)	0	0%	1	100%
Total	**99**		**10**	

3.43 Respondents reported a range of mechanisms to ensure these support services were culturally safe for students (although this often blurred into ways in which the program ensured teaching was culturally relevant or culturally safe). Mechanisms described included the following.

- Cultural safety or cultural competence training for academic and support staff.
- Employment of Aboriginal, Torres Strait Islander and Māori staff to provide pastoral support services including advocating for students within the education provider.
- Dedicated facilities or spaces to ensure culturally safe environments for students.
- Peer mentoring by other Indigenous students (although some recognised that this was challenging).
- Use of advisory committees to ensure that policies and procedures, curricula content and teaching materials are culturally safe.

Innovative practice

Examples of potentially innovative practice suggested by respondents included the following.

Teaching and learning

- Indigenous actors in simulation laboratory.
- Cultural learning activities including tours and recognition of significant events on the Aboriginal calendar.
- Development of online learning resources, with the input of Indigenous Peoples.
- Initiatives to provide healthcare services in Aboriginal, Torres Strait Islander and Māori communities, increasing student exposure.

Staff development and support

- Supporting innovation in teaching through Indigenous teaching grants and fellowship programs.
- Training for staff on cultural safety and cultural competence.

Supporting entry and participation

- Pathways to cadetships, internships and graduate years.
- Student scholarships.
- Reviewing selection processes to widen access and avoid unconscious bias.
- Supporting students through Indigenous student or qualified health practitioner mentors.
- Dedicated arrangements to assist with study skills including, for example, by allowing draft assignments to be submitted and by improving expectations of assessments by being more transparent.

Student intake

3.44 The survey sought to collect the following data from respondents at the program level for each of the years 2013–2018.

- Number of students commencing the first year of the program at the start of each academic year.
- Number of students commencing the first year of the program at the start of each academic year who have identified as Aboriginal and/or Torres Strait Islander and/or Māori.

3.45 The data collected are reported below (Table 14). The figures below should be treated with caution. Whilst student intake data were more consistently provided, respondents frequently did not provide any data for some or all years; indicated that such data was unavailable; or indicated that some data items may be estimated. In some cases, education providers said that data from the most recent year (2018) was pending. Data were not provided for 25% of programs. Any conclusions are based on incomplete data and therefore can only be tentative.

3.46 The data show that of 100,563 students reported to commence programs in the period 2013–2018, 3,195 or 3.2% of students were reported as identifying as Indigenous. There is an increase between the years of 2013 and 2017 of 75% in the number of students reported as identifying as Indigenous, compared to an increase in reported student intake of 47% over the same period.

3.47 There is variation between the professions but in many cases the number of programs providing data were very small. No data were collected for osteopathy or podiatry programs (Table 15).

Table 14. Students identifying as Aboriginal and/or Torres Strait Islander and/or Māori 2013–2018

Year	Student intake	Students identifying as Indigenous	% of students identifying as Indigenous
2013	13,121	379	2.9%
2014	15,889	454	2.9%
2015	17,260	571	3.3%
2016	17,431	584	3.4%
2017	19,338	662	3.4%
2018	17,524	545	3.1%
Total	**100,563**	**3,195**	**3.2%**

Table 15. Students identifying as Aboriginal and/or Torres Strait Islander and/or Māori 2013–2018 — by profession[2]

Profession	Student intake	Students identifying as Indigenous	% of students identifying as Indigenous	Number of programs providing data
Aboriginal and Torres Strait Islander Health Practice	1,228	1,370	111.6%	8
Chinese Medicine	398	4	1%	1
Chiropractic	4,779	20	0.4%	5
Dental	8,375	70	0.8%	41
Medical	18,670	184	1%	32
Medical Radiation Practice	1,354	–	–	2
Nursing and Midwifery	48,428	1,331	2.7%	28
Occupational Therapy	3,294	42	1.3%	10
Optometry	3,331	5	0.2%	5
Osteopathy	–	–	–	–
Pharmacy	5,467	17	0.3%	9
Physiotherapy	4,588	50	1.1%	15
Podiatry	–	–	–	–
Psychology	651	102	15.7%	8
Total	**100,563**	**3,195**	**3.2%**	**164**

3.48 In some cases, respondents provided student intake data for some or all years but did not or were unable to provide corresponding data for students identifying as Aboriginal and/or Torres Strait Islander and/or Māori, or vice versa. In an attempt to provide a more accurate picture, we excluded from analysis data we received from programs where we did not have data in the corresponding year for both student intake and students identifying as Indigenous. This excluded data from 64 programs from analysis (Table 16).

3.49 Table 16 shows that 4.7% of the revised sample identified as Indigenous. Excluding data from the Aboriginal and Torres Strait Islander health practice profession, for whom identifying as Aboriginal and/or Torres Strait Islander is a program entry requirement, this falls to 2.8%.

3.50 In the other professions, the percentage of students identifying as Indigenous varied between 0.2% (optometry) and 14.9% (psychology). Taking professions where data was collected from 10 or more programs, the range was between 1% (nursing and midwifery and dental) and 1.7% (physiotherapy).

2 For Aboriginal and Torres Strait Islander health practice, reported figures for intake were lower than the number of reported students who identified as Indigenous.

Table 16. Students identifying as Aboriginal and/or Torres Strait Islander and/or Māori 2013–2018 — by profession, adjusted

Profession	Student intake 2013–2018	Students identifying as Indigenous 2013–2018	% of students identifying as Indigenous	Number of programs providing data
Aboriginal and Torres Strait Islander Health Practice	1,208	1,208	100%	6
Chinese Medicine	398	4	1%	1
Chiropractic	285	16	5.6%	1
Dental	7,132	70	1%	27
Medical	12,755	164	1.3%	24
Medical Radiation Practice	–	–	–	–
Nursing and Midwifery	26,458	1,302	1%	13
Occupational Therapy	1,831	28	4.9%	5
Optometry	3,331	5	0.2%	5
Osteopathy	–	–	–	–
Pharmacy	5,152	14	0.3%	6
Physiotherapy	2,434	42	1.7%	10
Podiatry	–	–	–	–
Psychology	348	52	14.9%	2
Total	**61,332**	**2,905**	**4.7%**	**100**
Total (excluding Aboriginal and Torres Strait Islander Health Practice)	**60,124**	**1,697**	**2.8%**	**94**

The role of accreditation

3.51 The majority of respondents, 90%, agreed that the accreditation standard for their program(s) required them to assure the cultural safety of graduates (Figure 13).

3.52 The majority, 93%, considered that accreditation had at least some influence on curriculum design in the area of cultural safety (Figure 14).

Figure 13. Extent to which accreditation standards require programs to assure the cultural safety of graduates

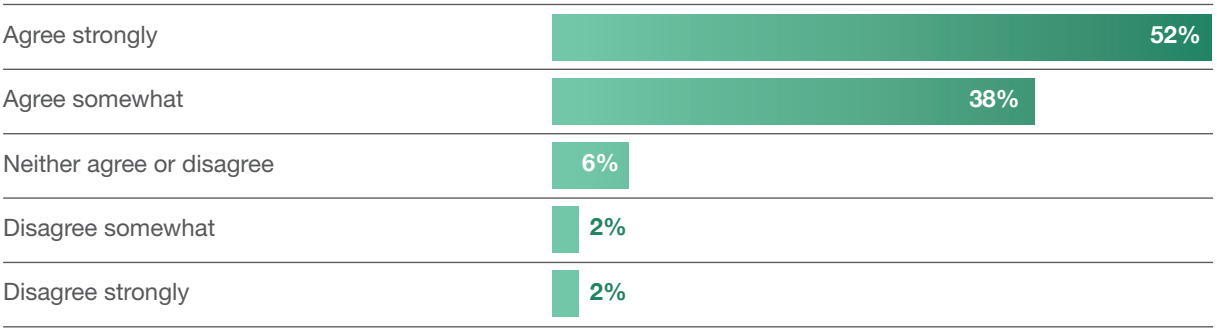
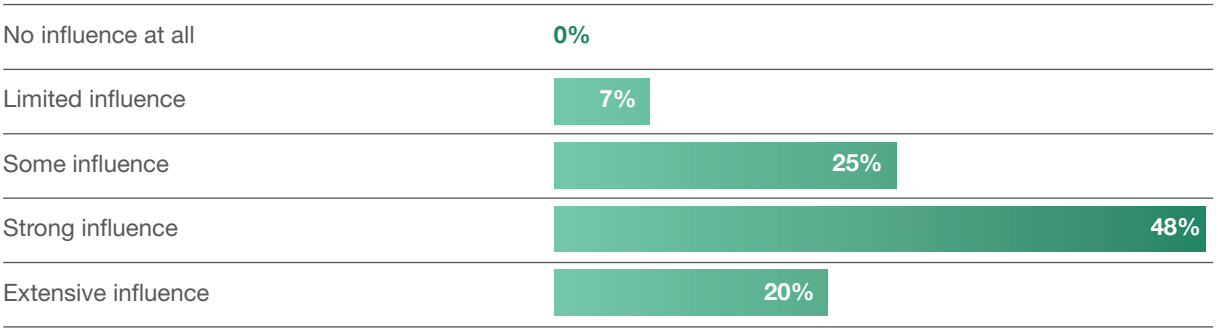


Figure 14. Extent to which accreditation influences curriculum design regarding cultural safety



3.53 Respondents were asked to identify 'opportunities' and/or 'limitations' that might be considered by accreditation authorities in supporting education providers to produce a culturally safe workforce. Responses identified a range of potential barriers or challenges to producing a culturally safe workforce. They also identified a range of enablers, including actions that could be taken by education providers and by accreditation authorities.

3.54 Barriers and challenges included the following.

- Ensuring sufficient numbers of staff with the required capabilities.
- Availability and retention of Indigenous persons to participate, for example, as members of advisory committees.
- Encouraging applicants / students to disclose their cultural background early in the program.
- Limited clinical experiences with Indigenous Peoples because of barriers between education providers and service delivery organisations.
- Lack of influence over what happens in the workplace – responsibility for a culturally safe workforce should be shared between health services, education and training providers and accreditation authorities. (This comment was specific to professional college training programs.)

3.55 Factors which would enable a culturally safe workforce included the following.

- Consensus around terminology would help provide clarity about exactly what education providers are required to assess.
- Increased funding and resources.
- Cultural safety or cultural competence training for all staff.
- Increasing the number of health practitioners from Indigenous backgrounds into the health professions.
- Engagement of Indigenous academics.

3.56 Accreditation was generally positively viewed as an enabler. A range of comments and suggestions were made about the role of accreditation including the following.

- Accreditation can provide a stimulus for improvement and standardisation through competencies, accreditation standards and support for/endorsement of relevant profession-specific Indigenous education frameworks.
- Accreditation can be used as leverage to secure funding and resources. Suggestions for requirements which should be placed on education providers included requirements to ensure recruitment, participation and retention of Indigenous staff and students.
- Consistent standards across professions would allow inter-professional learning and support institution-wide approaches.
- Accreditation authorities have the opportunity to support education providers by facilitating the sharing of good practice and providing more detail about how to deliver education which meets and delivers the required standards and competencies. For example, by providing more examples of practice for education providers to aspire to.

4. DISCUSSION

4.1 This section discusses the survey findings.

Education provider and profession analysis

4.2 Data are integral in measuring the impact of any future changes to accreditation systems. It is clear from the survey that there is a divergence in the health professions regarding the urgency of action needed regarding Aboriginal and Torres Strait Islander health outcomes. Responsiveness to requests for information varied across the professions.

4.3 It is estimated that at the time of the data collection there were approximately 1,067 programs or pathways to registration that were accredited in Australia and New Zealand by an accreditation authority.[1, 2] 112 responses were received and represented the data of 218 accredited programs across Australia and New Zealand. After adjusting for duplication or erroneous entries, 188 program responses were validated resulting in an 18% response rate. The highest response rates were received for the professions of Aboriginal and Torres Strait Islander health practice, chiropractic, dentistry, pharmacy, and optometry.

4.4 Health practitioner programs in Australia and New Zealand are delivered at many different levels and across a variety of provider types. Sixty seven per cent of responses were from universities or other self-accrediting higher education providers. Other respondents were from the VET sector (14%), specialist college (13%) or other provider types such as an Aboriginal Community Controlled Health Organisation or private provider (6%). Further analysis of the data shows a higher level of reported involvement of Aboriginal and/or Torres Strait Islander Peoples and/or Māori in programs delivered by higher education providers than by other education provider types. This was represented across all health profession programs delivered in higher education.

4.5 The Tertiary Education Quality and Standards Agency (TEQSA) is the regulator of the higher education sector in Australia. The Higher Education Standards Framework (HESF) 2015 is used by TEQSA to regulate both self-accrediting and non-self-accrediting education providers, with TEQSA directly accrediting higher education programs delivered by the latter. Domain 2 of the HESF refers to the student learning environment, setting requirements for diversity and equity; student wellbeing and safety; and student grievances and complaints. Section 2.2 specifically requires providers to demonstrate consideration of the recruitment, admission, participation and completion of programs by Aboriginal and Torres Strait Islander students. The impact of the strength of the HESF Domain 2 on the health profession programs alone is unmeasured by this survey. However, self-accrediting higher education providers were more likely to respond positively to having Indigenous advisors involved in their programs (70% of respondents), specific entry pathways for Aboriginal and Torres Strait Islander students (81% of respondents), and specific support services for Aboriginal and Torres Strait Islander students (70% of respondents). How the HESF complements the profession specific accreditation standards merits further analysis.

1 The accreditation authority for psychology accredits undergraduate degrees that are considered pre-requisite for entry to a psychology qualification which leads to eligibility to apply for registration or endorsement of registration. Therefore, the number counted as an accredited program is higher in this profession.

2 The accreditation authority for medicine accredits 127 programs. This number includes all the programs at specialty and field of specialty practice ('sub-specialty') level offered by the specialist medical colleges. For example, for surgery, as well as the specialty of surgery, it includes the field of specialty practice of neurosurgery. The survey did not specifically ask for responses at the sub-specialty level.

Professional competencies and learning outcomes

4.6 Professional competencies articulate the expected level of competence of a day one graduate from an accredited program. Learning or program outcomes are determined by education providers and mapped to the competencies. Professional competencies are either published by the accreditation authority for that profession, the relevant National Board or in some cases by the professional body representing that profession. Of the respondents, 79% reported that the professional competencies expected at the point of graduation articulate the requirements to respectfully treat, work with and understand patients who identify as Aboriginal and/or Torres Strait Islander and/or Māori. Furthermore, 76% of respondents reported that the learning outcomes are mapped to the competencies. The data shows the strength of specificity in professional competencies in recognising Aboriginal and Torres Strait Islander Peoples as a specific group and the importance of alignment of learning outcomes to the competencies.

Involvement of Aboriginal and Torres Strait Islander Peoples in programs

4.7 Accreditation authorities are interested to learn more about the level and extent to which programs involve Aboriginal and/or Torres Strait Islander Peoples in programs. Of the respondents, self-accrediting higher education providers represented the group with the highest reported involvement of Indigenous Peoples in their programs (68%). There were also high levels of reported involvement across all professions with the lowest reported involvement in dentistry which may be representative of the larger reporting sample. As expected, the profession of Aboriginal and Torres Strait Islander health practice reported a 100% involvement of Indigenous Peoples in their programs. The type of involvement reported included in teaching and learning activities and developing teaching approaches and materials. Other involvement included in planning, feedback and assessment, monitoring and evaluation and student admissions. There were lower reports of involvement in research in programs by Indigenous Peoples; an area for focus.

Cultural competence and cultural safety

4.8 Terminology used across programs varies. Education providers were asked to respond whether the terms cultural competence and cultural safety are used in their programs, whether they were different, how the learning outcomes related to the terms and to provide, where available, examples of learning outcomes where these terms are used. Cultural safety and cultural competence are likely to be assessed through written assessments, integrated into other assessable activities, specific/standalone scenarios or through clinical assessment.

4.9 Overall, it was clear from the responses that there is inconsistency in health profession programs as to the definition of cultural safety and how this relates specifically to Aboriginal and Torres Strait Islander Peoples. The work of the Strategy Group to consult on a shared definition of cultural safety is integral to the development of a shared and common understanding of what a safe health system is for Indigenous Australians.

Clinical experiences

4.10 The importance of clinical experience in treating and working with Aboriginal, Torres Strait Islander and Māori communities was explored. A high number of respondents reported they have no minimum requirement for their students to gain experience in treating or working with Aboriginal and/or Torres Strait Islander and/or Māori communities. Further when asked to estimate the percentage of students that do gain this clinical experience, 42% of the total respondents did not answer the question. Where there were responses, it was reported that this was difficult to track, not feasible for all students to have this experience, and that there are geographical and

financial challenges. For accreditation authorities, a shared understanding of how to measure if a program is producing culturally safe practitioners is important. Direct clinical experience may only be one mechanism that supports students in this learning process.

Curriculum design

4.11 In 2014, the Commonwealth Department of Health published the Aboriginal and Torres Strait Islander Health Curriculum Framework ('the National Framework'). Most accreditation authorities had commended this framework to education providers at the time however it was unknown as to whether the framework had been embedded into health programs. Most respondents were aware of the National Framework and 59% of respondents reported they use the National Framework or use it in combination with other frameworks to inform curriculum design. Further analysis indicates that the extent to which the National Framework was adopted varied, and a small number of education providers supported more profession specific frameworks.

Entry pathways and student support

4.12 The survey focused on specific pathways and support mechanisms in place within health practitioner programs for students identifying as Aboriginal and/or Torres Strait Islander or Māori. This was a poorly answered component of the survey with 48% of the respondents to the survey not providing information regarding alternative entry pathways to their program(s).

4.13 Higher education providers were more likely to report specific and alternative entry pathways for Indigenous students.

4.14 Examples of innovative pathways provided by respondents indicated some local and some scalable methods for entry and support for Indigenous students. Sharing these innovations across programs to encourage better support for Aboriginal and/or Torres Strait Islander and/or Māori students should be explored.

Student intake

4.15 Respondents were asked to provide data relating to the total student intake and the number of Indigenous students in each intake for the past six years. This proved difficult for some providers. The completeness of the dataset for some education providers appeared to improve in the latter years of reporting. Agreed metrics across the accreditation authorities regarding student intake data aligning with reports already provided to government or other regulatory bodies, may be a more accurate and less burdensome approach to analysing these data over time.

The role of accreditation

4.16 The strength of accreditation as a lever for change was reinforced by respondents with a majority confirming the accreditation standard requires their program to have regard for cultural safety and that the accreditation process influences curriculum design.

4.17 Accreditation authorities have an opportunity to collaborate and to have a shared approach to the use of the role of accreditation in effecting behaviour change within accredited health practitioner programs.

4.18 Respondents rightly point to the limitations of accreditation in affecting culturally safe work environments beyond graduation.

APPENDIX 1 — SURVEY QUESTIONS

Q. Which category of education provider best describes you? Please select one.

- University or other self-accrediting higher education provider
- Private higher or further education provider (non self-accrediting)
- Vocational Education and Training provider
- Specialist college
- Wānanga (New Zealand Specific)
- Aboriginal Health College
- Aboriginal Community Controlled Health Organisation
- Other (please specify)

Q. What is the name of the education provider you are responding on behalf of?

Q. Which accredited health practitioner programs do you offer? You may select more than one type of program

- Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice
- Chinese Medicine Program
- Chiropractic Program
- Dental Practitioner Program — Dental hygienist program
- Dental Practitioner Program — Dental prosthetist program
- Dental Practitioner Program — Dental therapist program
- Dental Practitioner Program — Dentist program
- Dental Specialist Program — Dento-maxillofacial radiology program
- Dental Specialist Program — Endodontics program
- Dental Specialist Program — Forensic odontology program
- Dental Specialist Program — Oral and maxillofacial pathology program
- Dental Specialist Program — Oral and maxillofacial surgery program
- Dental Practitioner Program — Oral health therapist program
- Dental Specialist Program — Oral medicine program
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- Dental Specialist Program — Orthodontics program
- Dental Specialist Program — Paediatric dentistry program
- Dental Specialist Program — Periodontics program

- Dental Specialist Program — Prosthodontics program
- Dental Specialist Program — Public health dentistry (community dentistry) program
- Dental Specialist Program — Special needs dentistry program
- Enrolled Nurse Program
- Medical Program (Primary)
- Medical Radiation Practitioner Program
- Medical Specialist Program — Addiction medicine
- Medical Specialist Program — Anaesthesia
- Medical Specialist Program — Dermatology
- Medical Specialist Program — Emergency medicine
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- Medical Specialist Program — Occupational and environmental medicine
- Medical Specialist Program — Ophthalmology
- Medical Specialist Program — Paediatrics and child health
- Medical Specialist Program — Pain medicine
- Medical Specialist Program — Palliative medicine
- Medical Specialist Program — Pathology
- Medical Specialist Program — Physician
- Medical Specialist Program — Psychiatry
- Medical Specialist Program — Public health medicine
- Medical Specialist Program — Radiation oncology
- Medical Specialist Program — Radiology
- Medical Specialist Program — Rehabilitation medicine
- Medical Specialist Program — Sexual health medicine
- Medical Specialist Program — Sport and exercise medicine
- Medical Specialist Program — Surgery
- Midwife Program
- Nurse Practitioner Program
- Occupational Therapy Program
- Ocular Therapeutics Program
- Optometry Program
- Osteopathy Program
- Pharmacy Program
- Physiotherapy Program
- Podiatric Surgery Program

- Podiatry Program
- Psychology Program
- Registered Nurse Program

Q. Where are these programs delivered? Please select one.

- Australia
- New Zealand
- Both Australia and New Zealand
- Other (please specify)

Q. Do the professional competencies expected at the point of graduation articulate the requirements to respectfully treat, work with, and understand patients who identify as Aboriginal and/or Torres Strait Islander (for Australian programs) and/or Māori (for New Zealand programs)?

[Yes, no or unsure for each category of program outlined above]

Q. How do you align program learning outcomes and requirements to respectfully treat, work with, and understand patients who identify as Aboriginal and/or Torres Strait Islander (for Australian programs)?

- Program outcomes are mapped to the list of competencies
- The program sets additional competencies
- The program has adopted another list of competencies for this requirement
- Other

Q. Are aboriginal and/or Torres Strait Islander People and/or Māori People involved in the program?

- Yes
- No

Q. In what ways are Aboriginal and/or Torres Strait Islander People involved in the program?

- Admissions and selection
- Developing teaching approaches and materials
- Planning and developing the program
- Teaching and learning activities
- Feedback and assessment
- Quality assurance, monitoring and evaluation
- Research
- Other (please specify)

Q. Do you have an advisor who identifies as Aboriginal and/or Torres Strait Islander, and/or Māori who has input to the design and/or delivery of your program of study?

- Yes
- No

Q. What is the seniority of this advisor? (e.g. contractor, Academic level etc.)

Q. Are cultural competence and cultural safety considered different terms, with different outcomes, in your program(s)?

- Yes
- No
- Not sure
- We use other terms in our program (please specify)

Q. What are the specific profession learning outcomes for cultural safety and/or cultural competence?

- Cultural safety
- Cultural competence
- Other

Q. What teaching and learning activities are used for cultural competence and/or cultural safety curriculum elements in your program?

Q. How is achievement of these competencies assessed? Please select all that apply.

- Written assessments
- Clinical assessments
- Oral assessments
- Simulation
- Assessment of these competencies is integrated into other assessment items
- There are specific questions / scenarios for these competencies
- Not assessed
- Other (please specify)

Q. Which of the following best describes the program(s) minimum requirement(s) for students to gain clinical experience in providing treatment for Aboriginal and Torres Strait Islander persons and Māori persons? Please select one response

- Aboriginal and Torres Strait Islander persons and/or Māori as patients or clients only
- Aboriginal and Torres Strait Islander and/or Māori communities only
- Both Aboriginal and Torres Strait Islander persons and/or Māori as patients or clients, and Aboriginal and Torres Strait Islander and/or Māori communities
- No minimum requirement is specified for either treatment of Aboriginal and Torres Strait Islander persons and/or Māori as patients or clients, or Aboriginal and Torres Strait Islander and/or Māori communities

Q. Can you estimate the percentage of your students who would normally gain exposure to providing treatment to Aboriginal and Torres Strait Islander and/or Māori persons and/or communities at the point of graduation?

Q. Are you aware of the Aboriginal and Torres Strait Islander Health Curriculum Framework that was published in 2016?

- Yes
- No
- Not sure

Q. How do you use the Aboriginal and Torres Strait Islander Health Curriculum Framework and/or another relevant curriculum framework to inform your curriculum design? Please select one.

- We use the Aboriginal and Torres Strait Islander Health Curriculum Framework to inform our curriculum design
- We use both the Aboriginal and Torres Strait Islander Health Curriculum Framework, and other Framework(s) to inform our curriculum design
- We do not use the Aboriginal and Torres Strait Islander Health Curriculum Framework, although we do use other Framework(s) to inform our curriculum design
- We use neither the Aboriginal and Torres Strait Islander Health Curriculum Framework, nor any other Framework(s) to inform our curriculum design
- We are a New Zealand Program of Study

Q. What are the 'other framework(s)' you use to inform curriculum design?

Q. You stated that you use the Aboriginal and Torres Strait Islander Health Curriculum Framework to inform your curriculum design, what aspects of the Framework do you use?

Q. You stated that you do not use the Aboriginal and Torres Strait Islander Health Curriculum Framework to inform your curriculum design, please explain the reasons why not?

Q. Are there specific entry pathways into your accredited program(s) for Aboriginal and/or Torres Strait Islander, and/or Māori students?

- Yes
- No

Q. What are the specific entry pathways into your accredited program(s) for Aboriginal and/or Torres Strait Islander, and/or Māori students? Please select all that apply

- Selection criteria
- Quotas
- Alternative entry pathways
- Other (please specify)

Q. What, if any, mechanisms do you have for identifying potential students from Aboriginal and/or Torres Strait Islander and/or Māori backgrounds?

Q. Do you have specific support services in place for Aboriginal and/or Torres Strait Islander, and/or Māori students?

- Yes, at a provider level
- Yes, at a program level
- Yes, at a provider and program level
- No

Q. What mechanisms do you use in these services to ensure cultural safety for students?

Q. Is your program of study incorporating any other actions to improve Aboriginal and Torres Strait Islander and/or Māori Health Outcomes that have not been covered above? In particular, please let us know of any innovative or successful actions which could be applied more broadly to other health practitioner programs.

Q. For each of the previous five program intakes (2013–2018), please indicate the total number of student enrollments (not offers) at the commencement of each intake. Please enter a whole number for each year. If you did not have an enrollment in that year please enter '0'. If your program is new and was not in place in a given year please enter 'N/A'.

[by profession/program]

Q. For each of the previous five program intakes (2013–2018), how many commencing students have identified as Aboriginal and/or Torres Strait Islander or Māori? Please enter the number for each year. If none in a year, please '0'. If you don't have this date please enter 'N/A'.

[by program and profession]

Q. To what extent do you agree that the accreditation standard for your program(s) requires you to assure the cultural safety of graduates?

- Disagree strongly
- Disagree somewhat
- Neither agree or disagree
- Agree somewhat
- Agree strongly

Q. To what extent does accreditation of your program(s) influence your curriculum design regarding cultural safety?

- No influence at all
- Limited influence
- Some influence
- Strong influence
- Extensive influence

Q. Can you identify any opportunities and/or limitations which may be considered by accreditation authorities in supporting education providers to produce a culturally safe health workforce?

Q. Which category of education provider best describes you? Please select one.

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Q. Can you identify any opportunities and/or limitations which may be considered by accreditation authorities in supporting education providers to produce a culturally safe health workforce?

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