Higher education in the Australian context: regulation or transformation in policy and practice

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Introduction
Tertiary education in the Australian context is increasingly subject to bureaucratic and centralized forms of standardization and regulation in curriculum content and teaching practice. This takes a particular bent in the education of health professionals such as doctors, nurses and allied health professionals. This paper draws on Braithwaite’s regulation theory (2008), and Timmermans and Berg's (2003) critique of evidence-based medicine, to outline the drive towards standardization in the education of health professionals in the Australian context. Both these theoretical positions outline the tensions between disorganization/creativity and regulation/standardization in capitalist economies in the 21 century. As a result of these developments educational reform in the University sector tends to be top down, rather than organic and led by government experts rather than academic professionals. This paper outlines some of these processes and implications for classroom practice and how resistance might be understood.

Regulation theory
Over the last two decades the move towards economic rationalist forms of government and the subsequent retreat of the welfare state has left the impression of a disorganized capitalism or laissez-faire approach to government. This is far from the truth. A more accurate account is that while on the one hand the state has moved to divest itself of a number of public services, such as water or electricity supplies, through the process of privatization under the banner of new public management, it has also increased its regulation over the operations of these services (Braithwaite 2008). Similarly, for those public services such as education and health, that have sections still directly funded through the state, both conservative and Labor governments in countries like Australia and Britain, have moved to extend their control over these services through increased regulation and the establishment of Independent Regulatory Agencies (IRA) (Braithwaite 2008; Gilardi 2005; Levi-Faur 2005).

The motivation for the establishment of IRA arises from the need to maintain some control over services whether they are privatized or not. The argument is based on the need to ensure continued equity in the distribution of government resources, along with transparency and efficiency, so that the state is seen to be engaged in a
process of independent auditing. Three points need to be made about the primary aim of government controlled regulation and the establishment of IRAs. Firstly, they continue the new public management agenda of increasing internal competition and subjecting the service to market forces. Sometimes these market forces are restricted to internal competition, at other times the service must compete with private for profit providers for government funds. Secondly, in the case of education and health, the move to control through regulatory authorities is a shift from self-regulation by the professions to indirect regulation by so called independent experts (read bureaucrats) appointed by governments. Thirdly, IRA are usually established through an act of parliament, that lasts beyond the life of the current government, thus allowing policy control to continue beyond the life of the party in power. This is supported by the argument that the control is now in the hands of independent experts (Maggetti 2008; Levi-Faur 2005; Gilardi 2005). Of course claims to independence are hollow since most IRAs are funded through taxing the very organizations they audit.

Evidence based medicine and health care
The EBM movement has its genesis, amongst other social forces, in the work of Archi Cochrane who noted that effective and efficient health care within the British NHS was not always a matter of resources. Sometimes it was simply a matter of using the most up to date and scientifically proven evidence. Given medicine’s claims that its foundations are in science this seems hardly insightful. However, Cochrane also noted that clinicians tended to treat their patients based on their experience rather than the evidence. Getting clinicians to change was highly problematic. The catalyst for precipitating change came from a number of sources. These were the potential of the internet to disseminate research evidence, attempts by governments and private health insurers to control medicine through managerial reforms, and the EBM movement itself which allowed for the rapid dissemination of protocols, clinical pathways, and clinical guidelines all based on research evidence. In short the EBM movement has paved the way for both the standardization of the clinical and health research process, and the standardization of practice.

In the early part of the 21st century the major sociological critique of EBM came from Timmermans and Berg (2003) in their classic study The Gold Standard: The challenges of evidence-based medicine and the standardization of health care. They argued that EBM resulted in conformity in both the research process, and in clinical practice. For example, the gold standard for progressing medical evidence is now the Randomized Controlled Trial (RCTs), all other forms of research are considered inferior in the hierarchy of evidence. In the last decade RCTs have become the benchmark for clinical evidence and the basis for standardized clinical protocols, pathways and guidelines as EBM consortiums such as the Cochrane Collaboration have been established throughout the world. In short both the process for doing the research and the process of clinical practice is highly ritualized and standardized. Critics such as Timmermans and Berg, and many medically trained clinicians
themselves, note that this risks producing a cookbook approach to medicine, and to the reduction of the profession to a trade rather than an art. Timmermans and Berg’s reflections drew parallels between the EBM movement and Harry Braverman’s critique of scientific management, early 20th century Taylorism, and industrial management.

Three points are worth noting about the impact of EBM on university education; firstly those educating medical, nursing and allied health professionals take seriously the EBM movement. Both the processes of research and practice are taught. This would not be problematic were it not for the second point; this is the increasing pressure on Universities to make graduating students ‘road ready’. The pressure on universities to respond to industry needs reinforces the focus on protocol and formulaic approaches to research and clinical practice - readily found in the EBM movement. A third factor is the increasing regulation and auditing exercised over university education.

Higher education in Australia and standardization
Concurrently with the EBM movement two major developments in Australian tertiary education for health professionals provide further policy support for the drift towards standardization in educational and classroom practice. These are the Bradley Review (2009) on higher education and the subsequent establishment in 2011 of the Tertiary Education Quality and Standards Agency (TEQSA), and the formation Health Workforce Australia (2009) and the Australian Health Practitioners Regulation Agency (AHPRA).

Federal government reforms in education
The Bradley Review of Higher Education and subsequent Federal legislation has deregulated the university sector in the interest of enabling increased numbers of disadvantaged populations to access higher education. Targets include: 40% of 25 to 34 year-olds to graduate by the year 2040;

- 20% of low socioeconomic students (including rural/remote/Indigenous) to be enrolled in universities by 2020;
- A demand-driven system resulting in effective deregulation of student numbers, or a voucher system, in the majority of university courses. Medicine will be exempt.

The Bradley Review also recommended a 10% increase in funding for teaching and learning. This was rejected by the Rudd Labor government, but they agreed to review the base and discipline cluster funding in 2011. This is currently in train and expected to report in late 2011. Approximately $437 million has been allocated to initiatives that support increased participation by low socioeconomic students. The government has also agreed to changes in the indexation rate.
These policy shifts are predicted to lead to internationally determined, and nationally imposed benchmarks and standards, in order to overcome the perverse incentives built into the reforms that have constructed the sector as a market engaged in internal as well as broader competition with the private sector. This acknowledged need for regulation, led the Federal government to establish the Tertiary Education Quality Standards Agency (TEQSA) in 2011. Its stated aim is to make the system more student centered and focused; defined by increased student as consumer choice. The avowed direction of the Bradley review is to create an internal market within government funded institutions and a capitalist market between them and private providers where students are defined as the customers. As one commentator noted, it is terrifying to think that higher education in Australia will be subject to the market forces of teenagers, who are presumed to know more about education than their lecturers (Buchanan 2011).

The TEQSA will replace the current Australian Universities Quality Agency (AUQA). Unless the audit process is to change radically, quality will be assessed through the usual mechanisms of checking for bureaucratic and committee processes for course and topic changes, quantitative student evaluations of teaching, peer reviews, and grant and research output usually measured through publications, impact factors and citations. The one public agency vested with the responsibility to encourage teaching excellence and innovation, the Australian Learning and Teaching Council, was defunded as a result of budget cuts arising from the 2011 Queensland summer floods and is in its last year of operation. The regulator, TEQSA will be both funder of teaching performance incentives as well as regulator.

Practical implications at the local level
The practical implications of a bureaucratic approach to education is a familiar one. It includes the usual points raised above about ensuring processes for the establishment of courses and topics, or for changing assessment. Currently in Australia, universities must report all major course and topic changes to Canberra at least 6 months before they are implemented. Peer assessment of classroom performance is the current rage within a number of universities. Peer assessment epitomizes the problem; it is used as both a genuine exercise in collegial feedback and as a mechanism for certification and supervision. Templates for practice tend towards assessing classroom performance, or the quality of written materials. There is little evidence of engaging with lecturers around their philosophy of education, or with students about the possibilities for them to engage with staff in the process of becoming educated. A third familiar strategy is the student evaluation of teaching processes where quantitative likert scale evaluations are done at the end of the semester and then become the public benchmark for good teaching.

Federal government reforms in health workforce planning
At the same time as the policy and regulatory reforms of Universities has been in progress the government has moved to deal with the health workforce crisis. This
has seen the Council of Australian Governments (COAG) establish two regulatory authorities to manage the accreditation, registration, and the clinical education of health professionals. This in turn as led to tensions between the university sector, the professions, and Health Workforce Australia over what constitutes acceptable clinical education as incentive based funding is used to reorientate the curriculum. HWA funding has also enticed universities to enter into partnerships with the private health sector drawing on new public management processes whereby the lines between public and private are blurred illustrating Hardy’s points that private providers are able to increase their spread of profit making through the dispossession of the welfare state (Harvey 2003 quoted in Whiteside 2011). Examples include contracting SpecSavers to provide clinical education for optometry students and the provision of capital funds to private GP clinics for the education of medical students. While it can be argued that these developments are inevitable, given the public-private mixed nature of the Australian health care system, the shift from public to private clinical practice is altering the landscape of health professional education. It is now increasingly viewed as a commercial transaction (and burden), rather than an engagement between two professionals; one a novice, the other an expert involved in a nurturing and educational generational exchange.

**Practical implications at the local level**

At the practical level the way in which HWA uses EBM is instructive of their reductionist approach to health professional education. The most telling area is in the number of hours funded for clinical practice. One of the first research projects HWA engaged in was to gather data on the number of hours universities allocated to clinical practice for each profession and to then use this to argue that the ‘evidence’ was arbitrary and to set its own benchmark. HWA allocation of hours is independent of the standards set by professional associations, leaving universities to find alternative funding to make up the deficit. For example, the Dietetics Association of Australia requires universities to provide a hundred days of clinical placement for accreditation and registration, HWA funds 87 days based on a 7 hour day (DAA 2011). Further, funding is provided for increases in student numbers, but not for innovations in clinical practice, although high levels of quarterly reporting are required. Similarly, the newly formed Australian Health Practitioners Regulation Agency, tasked with managing registration and accreditation and standardising it across the country, requires universities to monitor and report on student’s suitability for practice. This is in sharp contradiction to the notion of student as customer in a competitive market. Lecturers are now agents of the state (not the profession) tasked with ensuring the money is not wasted and that the novice professional is a viable product.

**The purpose of education**

The difficulty with the policies and practices outlined above is that education is constructed as a form of competitive entertainment performed in a highly regulated environment. Reforms in education have called for competition measured by
performance; reforms in health workforce policy have resulted in the state determining how clinical education is defined, while reforms in medicine risk enhancing this standardization. The evidence-based medicine movement while not directly related to education has much in common with the regulation movement. The focus on research protocols and hierarchies of evidence that go well beyond clinical medicine into policy and health, reinforce the cultural of standardization, and ritualization and risk losing touch with the serendipitous nature of innovation.

This is not the key purpose of education, especially for disadvantaged groups who have traditionally not accessed higher education. Presumably even the most economically driven government wants to engage disadvantaged groups in order to increase their skill and productivity base, and to provide these populations with the opportunity for financial and cultural transformation. This is simply good economics. Most critical educational supporters of tertiary education go further and argue that a university education challenges students taken for granted understandings of the world (Buchanan 2011) in order to produce an informed citizenry. In this scenario higher education is seen as a public good; it brings both economic opportunities and richness to civil society. More marginal ideas on the purpose of tertiary education suggest its purpose is to transform the novice student into a professional. This includes two key ideas; the first deals with ensuring the student embraces the underpinning theories of the discipline (which includes evidence-based medicine) and incorporates these into their practice, and secondly, that as students move from novice to beginner practitioner that they integrate knowledge and skills into a personal philosophy of practice. The ethics of professional practice demands this - and if achieved would certainly reduce the workload of the regulatory authorities.

**Education for transformation**

Education for transformation requires practice at a number of levels. Until there is a serious examination of the value of the economic rationalist endeavours of new public management and privatization it is unlikely that governments or senior management of the various university decision and lobby groups will work for change. This does not mean that universities, faculties, and individuals cannot continue to incorporate strategies that take a broader approach to the purpose of university education. Many do. The first tongue in cheek recommendation is to reinstitute the staff tea room and to take time out for staff to meet regularly and informally. This recommendation is in line with the wisdom of Curry and colleagues (2008 cited in Buchanan 2011 p 71) who suggest that teachers learn through ‘situated and social interactions with colleagues who process distributed expertise and with whom they have opportunities for sustained conversations related to mutual interests’.

Recent critiques of Evidence-based medicine point to the fact that despite its promise it has not brought about significant changes in clinical practice (Timmermans and Mauck 2005). Timmermans and colleagues have demonstrated
that a major motivation for clinicians to change their practice in line with the evidence is the influence of peers, especially multidisciplinary engagement with nurses and allied health professionals. The theoretical ideas behind this can be found in the Interprofessional Education (IPE) and practice movement. Here the research suggests that the most creative way to design clinical pathways that continue to incorporate EBM is through a process of multidisciplinary collaboration. University education programs that seek to educate health professionals in this approach have much potential. It however, requires them to incorporate what is positive about the EBM movement, along with the alternative evidence that comes from the lived experience of nurses and allied health practitioners. This is a major challenge to the idea of hierarchies of knowledge at the core of EBM.

A third level of attack is through classroom practice. This includes the usual strategies for developing a relationship with students such as ensuring you know their names, and meeting them individually in order to understand their aspirations. A further approach is through using the student evaluation processes in an innovative way. This involves alerting students to the nature of the exercise and to what will be evaluated. It seems strange that students have not been incorporated into the critique of the current system and asked to collaborate in the resistance. Outlining for them early in the term or semester that the formal university protocols will be used mid semester, but that an additional evaluation will take place that focuses on investigating a shared understanding of the education process could be enlightening. One approach is to use the standard university tools mid way through the course as a process for improving the performance of both teaching staff and students. A second evaluation after exams and assessment using a focus group approach might then explore to what extent the topic contributed to the broader educational aim of transformation to professional. This form of evaluation might ask students to what extent they engaged in the topic, came prepared to discuss the issues, interacted with other students during the week to discuss the ideas, thought about the material at other times, made connections between items in the news and the material under discussion, or reflected critically on the topic content and how it might impact on their practice. Conversely such evaluations might also ask students to reflect on how well teaching staff pointed the way to transformation or deepened their understanding of the profession. Highlighting these points early in the topic allows the student to understand where the process is headed.

**Conclusion**

An education solely focused on the development of skills for the workplace does not allow the cultural transformations once assumed to be a core part of higher education. The current approach being pursued by the Federal government in Australia seeks to provide a well trained workforce, but not a well-educated professional or citizenry. Much of this is put in place through a process of regulatory agencies whose role is to set targets and audit performance. This puts those
disadvantaged groups presumed to benefit from these reforms at a distinct cultural disadvantage.

References

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