## COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

### Colleges Only Session 11:30-1pm

<table>
<thead>
<tr>
<th>Item #</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
<th>Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td><strong>Guests and Presentations</strong></td>
<td>Introduced by Chair</td>
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<tr>
<td>4.1</td>
<td>11:30am</td>
<td>Address from the Australian Medical Association to CPMC</td>
<td>Dr Stephen Parnis Vice-President</td>
<td>✓</td>
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<tr>
<td>4.2</td>
<td>12MD</td>
<td>National Prescribing Service &amp; Choosing Wisely Initiative</td>
<td>Dr Lyn Weekes, CEO</td>
<td>✓</td>
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<tr>
<td>4.3</td>
<td>12:30</td>
<td>Australian Academy of Health &amp; Medical Sciences</td>
<td>Professor Louise Baur, Councillor</td>
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### 1pm – 1:30pm LUNCH College Presidents and CEOs

### Presidents Only 1:30-3pm: Governance

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Action Required</th>
<th>Paper</th>
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<tbody>
<tr>
<td>5</td>
<td>1:30</td>
<td>Governance</td>
<td>For approval</td>
<td>✓</td>
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<tr>
<td>5.1</td>
<td></td>
<td>Minutes from previous meeting</td>
<td>For noting</td>
<td>✓</td>
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<td>5.2</td>
<td></td>
<td>Business Arising</td>
<td>For noting</td>
<td>✓</td>
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<td>5.3</td>
<td></td>
<td>Chair’s report</td>
<td>For noting</td>
<td>✓</td>
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<tr>
<td>5.3.1</td>
<td></td>
<td>Executive minutes</td>
<td>For noting</td>
<td>✓</td>
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<td>5.3.2</td>
<td></td>
<td>Executive government relations day</td>
<td>For noting</td>
<td>✓</td>
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<td>5.4</td>
<td></td>
<td>CEO’s report</td>
<td>For noting</td>
<td>✓</td>
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<td>5.5</td>
<td></td>
<td>Financial statements</td>
<td>For noting</td>
<td>✓</td>
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<td>5.6</td>
<td></td>
<td>Changes in Directors</td>
<td>For noting</td>
<td>✓</td>
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<tr>
<td>5.7</td>
<td></td>
<td>Other Governance matters</td>
<td>For Noting</td>
<td>✓</td>
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<td>5.8</td>
<td></td>
<td>Rotating CPMC meetings</td>
<td>For decision</td>
<td>✓</td>
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<tr>
<td>5.9</td>
<td>1:45</td>
<td>In-camera session Presidents only</td>
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### Strategic Discussion

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<th>Time</th>
<th>Agenda Item</th>
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<tr>
<td>6</td>
<td>2pm</td>
<td><strong>Strategic Discussion</strong></td>
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<td>6.1</td>
<td></td>
<td>Indigenous Health Sub-Committee Common Governance forum</td>
<td>For decision</td>
<td>✓</td>
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<td>6.2</td>
<td></td>
<td>National Medical Training Advisory Network – strategic approach</td>
<td>For discussion</td>
<td>✓</td>
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<tr>
<td>6.3</td>
<td></td>
<td>CPMC Business plan report + roundup from strategic planning forum</td>
<td>For discussion</td>
<td>✓</td>
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<td>6.4</td>
<td></td>
<td>Fee review – capping rates</td>
<td>For decision</td>
<td>✓</td>
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<td>6.5</td>
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<td>Rural Health Continuing Education</td>
<td>For decision</td>
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<td>6.6</td>
<td></td>
<td>Senate Inquiry into Medical Complaints</td>
<td>For decision</td>
<td>✓</td>
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<td>6.7</td>
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<td>Enquiry into Private Health</td>
<td>Update</td>
<td>✓</td>
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<td>6.8</td>
<td></td>
<td>MBS review</td>
<td>Update</td>
<td>✓</td>
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<td>6.9</td>
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<td>Next College presentations</td>
<td>For decision</td>
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### Evaluation

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>3pm</td>
<td>Evaluation</td>
<td>Verbal</td>
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</tbody>
</table>

### 3pm Next Meeting: 2 June 2016 MELBOURNE

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Note</th>
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<tbody>
<tr>
<td>8</td>
<td>3pm</td>
<td>Next Meeting: 2 June 2016 MELBOURNE</td>
<td>Note</td>
</tr>
</tbody>
</table>
Colleges Only Session Item 4: Guests

Members will note the address to CPMC by the AMA followed by two presentations.

4.1 An Address by the Australian Medical Association (11:30am)

At the November 2015 CPMC meeting members expressed a concern that the President of the AMA was not attending the meetings. For a variety of reasons the AMA had been sending their Secretary-General Ms Anne Trimmer, instead of the President, and the reports were considered useful but possibly constrained given the presence of government and other stakeholders at the table. As a result the AMA was approached by CPMC to consider making a separate address to the Colleges and because Professor Owler is overseas for the February 2016 meeting the address will be given by Dr Stephen Parnis, Vice-President of the AMA.

About the AMA

For the members information the Australian Medical Association was formed in 1962. The AMA sees itself as the most influential membership organisation representing registered medical practitioners and medical students of Australia. The AMA seeks to promote and protect the professional interests of doctors and the health care needs of patients and communities. The AMA website states it as ‘Leading Australia’s Doctors – Promoting Australia’s Health’.

About Dr Parnis – picture sourced via twitter @SParnis

Dr Stephen Parnis is an Emergency Physician based in Victoria and is the Vice-President of Federal AMA. He is Chair of the Federal AMA Council of Salaried Doctors. He has a particular interest in the welfare of physicians and GPs in emergency situations, as well as in areas such as aged and palliative care policy. Dr Parnis was involved in student politics while at the University of Melbourne and has been active as a spokesperson for AMA Victoria.

The AMA will address CPMC on issues of importance and there will be an opportunity to discuss matters of common interest.
4.2 Presentation from the CEO, Dr Lyn Weekes, National Prescribing Service on the Choosing Wisely Initiative at 12MD

According to the NPS website the NPS is ‘an independent, not-for-profit and evidence based organisation, providing practical tools to improve the way health technologies, medicines, and medical tests are prescribed and used. The NPS works across Australia and throughout the Asia-Pacific region to positively change attitudes and behaviours which exist around the use of medicines and medical tests, so that consumers and health professionals are equipped to make the best decisions when it counts.’ (http://www.nps.org.au/about-us)

Dr Weekes wrote to CPMC on 21 January 2016 to accept the invitation to address the CPMC on the NPS MedicineWise and Choose wisely Initiative. There has been some interest in the initiative both in Australia and by our New Zealand counterparts. There are 20 participating organisations including the following CPMC members:

- Australasian College of Dermatologists
- Australasian College for Emergency Medicine
- College of Intensive Care Medicine
- Royal Australian College of General Practitioners
- Royal College of Pathologists of Australia
- Royal Australian and New Zealand College of Ophthalmologists
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australian and New Zealand College of Radiologists
- Royal Australasian College of Physicians
- Royal Australasian College of Surgeons.

This item will allow members to receive an update on Choosing Widely Australia. Members may wish to note that this initiative also exists in the US (http://www.choosingwisely.org/) and in the UK and Canada as well as developing in India. At the CMC New Zealand meeting members noted that Choosing Wisely is spreading worldwide. The point of this discussion with Dr Weekes is to learn more and to enable engagement.

Biography: As inaugural chief executive officer of NPS MedicineWise, Lynn has contributed significantly to the development of quality use of medicines (QUM) resources and services for health professionals and consumers in Australia since 1998.

In the 2013 Queen's Birthday Honours, Lynn was appointed as a Member of the Order of Australia for her significant service to Australian community health through the promotion of quality use of medicines. With her expertise in the QUM area Lynn sits, by invitation, on various national boards and committees from government, pharmacy and academic sectors. As part of her PhD thesis, Organisational Structures to Promote Quality Use of Medicines, Lynn developed indicators for QUM for drug and therapeutics committees and for hospitals more generally. She has a strong professional interest in quality assurance, behaviour change and pharmacoepidemiology.

Prior to Lynn’s appointment to NPS MedicineWise, she was executive officer of NSW Therapeutic Assessment Group where she was involved in drug use practice, evaluation and policy. She originally trained as a pharmacist and practised in hospital and research settings.
4.3 Presentation from Councillor Professor Louise Baur, Australian Academy of Health & Medical Sciences on the Academy at 12:30pm

The AAHMS developed out via the Group of Eight universities, the Department of Health and the NHMRC following recommendations from the McKeon Report of 2013 which examines health and medical research. In 2014 the Academy was launched and CPMC assisted them in the process. http://www.aahms.org/history/ Members may wish to peruse the FAQs on the AAHMS website at: http://www.aahms.org/faq/

About Professor Louise Baur – sourced from the University of Sydney

Professor Louise Baur is a paediatrician and an internationally renowned childhood obesity researcher. She has a special interest in the prevention and management of child and adolescent obesity and has for over 20 years also studied various aspects of adult obesity. Professor Baur is a founder of ACAORN (Australasian Child and Adolescent Obesity Research Network) and is an active member of The Prevention Research Collaboration, a specialised research group within the Sydney School of Public Health. Professor Baur engages widely with professional organisations and the community. She is a member of the WHO Ad Hoc Working Group on Science and Evidence for Ending Childhood Obesity and Associate Director of the University of Sydney’s WHO Collaborating Centre in Physical Activity, Nutrition & Obesity. She is a Founding Fellow and Council Member of the Australian Academy of Health & Medical Sciences (launched in March 2015). She is a Director of World Vision Australia and a member of the Governing Board of the Sydney Children’s Hospitals Network. She has received numerous awards recognising her many contributions. In 2010 Professor Baur was awarded Member of the Order of Australia (AM) ‘for service to medicine, particularly in the field of paediatric obesity as a researcher and academic, and to the community through support for a range of children’s charities’. (http://sydney.edu.au/medicine/people/academics/profiles/louise.baur.php)

Members may wish to enquire about ways in which the two organisations can formally cooperate on matters of common interest.
Minutes of the 112th meeting of the Committee of Presidents of Medical Colleges held at on Thursday 12th November 2015 at the Royal Australian College of General Practitioners, 12 Mount Street, North Sydney

Present
Professor Michael Hollands  Chair
Professor Nicholas Talley  Chair-elect
Dr Anthony Cross  Australasian College of Emergency Medicine
Professor Bala Venkatesh  College of Intensive Care Medicine of Australia and New Zealand
A/Professor Peter Stewart  Royal College of Pathologists of Australasia
A/Professor Frank Jones  Royal Australian College of General Practitioners
A/Professor Lucie Walters  Australian College of Rural and Remote Medicine
Professor Malcolm Hopwood  Royal Australian and New Zealand College of Psychiatrists
Professor Michael Permezel  The Royal Aust & NZ College of Obstetricians and Gynaecologists
Dr Genevieve Goulding  Australian and New Zealand College of Anaesthetists
A/Professor Chris Milross  The Royal Australian and New Zealand College of Radiologists
Professor David Watters  Royal Australasian College of Surgeons
Dr Bradley Horsburgh  Royal Australian and New Zealand College of Ophthalmologists
A/Professor Chris Baker  Australasian College of Dermatologists
Professor Michael Cleary  Royal Australasian College of Medical Administrators
Dr Catherine Yelland  Royal Australasian College of Physicians

College Chief Executives
Mr Tim Wills  Australasian College of Dermatologists
Dr Peter White  Australasian College of Emergency Medicine
Mr Phillip Hart  College of Intensive Care Medicine of Australia and New Zealand
Dr Zena Burgess  Royal Australian College of General Practitioners
Dr Karen Owen  Royal Australasian College of Medical Administrators
Ms Linda Smith  Royal Australasian College of Physicians
Ms Alana Killen  Royal Aust and NZ College of Obstetricians and Gynaecologists
Mr Andrew Peters  Royal Australian and New Zealand College of Psychiatrists
Dr Debra Graves  Royal College of Pathologists of Australasia
Dr David Andrews  Royal Australian and New Zealand College of Ophthalmologists
Ms Michelle Thompson  Australasian College of Sports Physicians
A/Professor David Hillis  Royal Australasian College of Surgeons
Ms Pamela Taylor  Royal Australian and New Zealand College of Radiologists

Professional Observers
Mr Ian Frank  CEO, Australian Medical Council
Dr Joanna Flynn  Chair, Medical Board of Australia
Professor Christopher Baggoley  Commonwealth Chief Medical Officer
Dr Andrew Singer  Principal Medical Advisor, Department of Health
Mr Chris Robertson  Executive Director, AHPRA
Dr Sean White  Vice President, Australian Indigenous Doctors Association
Ms Anne Trimmer  Secretary General, The Australian Medical Association
Professor Nicholas Glasgow  President, Medical Deans Australia and New Zealand
The Hon. Carmel Tebbutt  Chief Executive, Medical Deans Australia and New Zealand

In Attendance:
Ms Angela Magarry  Chief Executive Officer
Mr Michael Davidson  Program Manager, Rural Health Continuing Education (RHCE)
1. WELCOME AND INTRODUCTION
At 9:00am, Professor Michael Hollands opened the meeting and welcomed those in attendance. The Chair recognised the traditional owners of the land.

Professor Hollands noted there were new presidents at the Australasian College of Emergency Medicine, and the Royal Australasian College of Medical Administrators, and welcomed Dr Sean White (AIDA), Dr Catherine Yelland (RACP), and The Hon. Carmel Tebbutt.

The Chair also noted this was the last meeting for Dr Anthony Cross (ACEM), A/Professor Peter Stewart (RCPA), and A/Professor Chris Milross (RANZCR).

1.1 Apologies Tendered
Professor Robin Mortimer (AMC), Mr Martin Fletcher (AHPRA), Professor Villis Marshall (ACSQHC), Professor Anne Kelso (NHMRC), Dr Kali Hayward (AIDA), Professor Richard Tarala (CPMEC), Dr Michael Jamieson (ACSP), John Ilott (ANZCA), Marita Cowie (ACRRM)

1.2 Conflicts of Interest and Confidentiality
Members were asked to declare any conflicts of interest, and no declarations were made.

1.3 Other issues
No other issues were raised.

2. FORUM REPORTS
2.1 Committee of Presidents of Medical Colleges
Professor Hollands informed members that CPMC has been actively working to preserve the RHCE Program, although there is no progress at the Department of Health to reposition it in Primary Health Networks.

The Chair met with AIDA to discuss how to work together to improve opportunities for Aboriginal medical specialists.

Professor Hollands met with the Secretary of the Department of Health, Martin Bowles, regarding health workforce, data mining and privacy issues. He noted that as Colleges collect data in different ways, this can present a challenge for the Department to interpret the data. Also discussed were issues surrounding private health funds’ attempts to move into family practice.

The Chair noted that bullying and harassment is a major issue currently, and will be discussed by Professor David Watters (RACS) later in the meeting.

Members noted that the Chair had also been working closely with Minister Ley regarding the MBS Review, and particularly the placement of clinicians on the panel.

The Chair noted that CPMC is making progress with the National Medical Training Advisory Network (NMTAN) on the number of doctors trained. He expressed concern that too many medical students continued to be trained when there would not be worthwhile training places available for them upon qualification.
2.2 **Australian Medical Council**

Mr Ian Frank noted Professor Robin Mortimer was a late apology, and spoke to the report noting four main points:

- **A/Professor Jill Sewell AM** will step down as Chair of the Specialist Education Accreditation Committee (SEAC). Expressions of Interest for a new chair have been invited, and recommendations will be made to Council in the week starting 16 November.

- The National Registration and Accreditation Scheme (NRAS) Review – one outcome of the review will be for another review of accreditation in Australia. Also, Mr Frank noted that the current report has some serious flaws in the way it was costed.

- The Review of Accreditation Standards has been finalised. New standards will come into effect from 1 Jan 2016. The Council will need to work with Colleges during the transition to the new standards. One workshop has already been held, with another planned for early 2016. Mr Frank noted that the trainee wellbeing standard will be a key difference, and the Council is looking for what steps each College is taking to address the wellbeing of trainees, rather than a definitive solution. If a College considers the accreditation process around harassment to be unrealistic or unfair, the Council has an internal appeals process.

Members discussed professionalism of medical students and fitness to practice. Mr Frank noted that the behaviours and attitudes of students are not being picked up in medical school, and then are translating into problems in practice later. The Council has a group working on professionalism and how to progress the issues surrounding it.

- Ministers are still interested in the recommendations from the *Lost in the Labyrinth* report. The Council has been working to streamline the procedure for Primary Source Verification (PSV). International Medical Graduates (IMGs) will be able to apply through the Educational Commission for Foreign Medical Graduates (ECFMEG) to have their qualifications verified prior to processing. This method will improve the timeliness of PSV.

2.3 **Chief Medical Officer**

Australia’s Chief Medical Officer, Professor Chris Baggoley was accompanied by Dr Andrew Singer, Principal Medical Officer, Department of Health. Professor Baggoley congratulated Professor Hollands on his term and welcomed the prospect of working with incoming Chair, Professor Nicholas Talley. Professor Baggoley noted his report and opened the forum to questions.

Professor Bala Venkatesh (CICM) raised workforce modelling and projections, voicing a concern that the medical shortage list should be reviewed, as every specialty is saturated. Dr Singer noted that Tarja Saastamoinnen of Access Branch is leading this process and consulting widely. Members noted any change would be a decision for the Department of Immigration, however the Health Department aims to provide the best informed advice to them. Dr Singer continued, noting that as long as maldistribution continues to be a problem, people will want to bring overseas trained specialists in.

Professor Lucie Walters (ACRRM) stated that the decision to defund the Prevocational General Practice Placements Program (PGPPP) has impacted on intentions of doctors, and created a major hole in the training pipeline. Members noted that 87% of those who
undertook a PGPPP placement showed an increase in the intention to practice in primary care. Professor Walters indicated that PGPPP had made a big difference in engaging people in primary practice, and furthermore had increased the opportunity for prevocational trainees to consider rural practice. Dr Singer noted that while there are no plans to re-fund PGPPP, there are opportunities with the ongoing review of intern training with regards to how community placements for interns and other prevocational doctors are supported.

Professor Venkatesh noted that the Health Workforce Division of the Department wanted Colleges to provide submissions on health workforce projections, and requested a response to the CPMC detailing what the final submission was. Dr Singer noted he would talk to Tarja Saastamoinen about it.

**Action – Information to be provided to the CPMC on the results of the health workforce projection submissions provided by Colleges to Health Workforce Division**

2.4 National Health and Medical Research Council
The Chair noted that no paper had been provided by NHMRC, and Professor Anne Kelso was an apology.

2.5 Medical Board of Australia
Dr Joanna Flynn, Chair, Medical Board of Australia discussed her report, highlighting the following matters:

- The NRAS Review delivered two recommendations that relate to Colleges, one regarding the implementation of the changes arising from the *Lost in the Labyrinth* report; and the other relating to the performance of Colleges in applying standard assessments of IMG applications, and applying benchmarks for timeframes on completion of assessments. The Board will report to the Australian Health Workforce Ministerial Council on this in December.
- There has been considerable progress on the *Lost in the Labyrinth* recommendations. While the process for streamlining IMG applications is progressing, the Board recognises there are IMGs that are still concerned about costs, timeliness, fairness and transparency, and the Board and Colleges will need to keep this discussion going.
- Colleges have been very engaged on IMG assessment guidelines, providing data on College processes. The data has been collated and will be presented to Ministers and then published.
- A meeting on revalidation took place in Montreal in late October, with Dr Lee Gruner attending on behalf of CPMC. Discussion included the CPD gaps of specialists, and what the minimal level of competence should be. Work in this area will need to be defensible, make sense, have value, be cost effective and not duplicate existing work.
- The Board will meet with the Medical Council of New Zealand and specialist colleges on 4 Dec. The Board is mindful to align Australian and Medical Council of New Zealand requirements whenever possible for consistency.
- The Board is hosting the International Association of Medical Regulatory Authorities (IAMRA) 12th International Conference on Medical Regulation on 20-23 September 2016.
- Regarding the current review of internship, Ministers have established an implementation group, to be chaired by Robin Burley. The group will consider the recommendations of the review and advise on the next steps.
- Dr Flynn thanks Professor Hollands for his chairmanship and welcomed the new Chair, Professor Talley.
Questions and general discussion ensued, and the following topics were discussed:

- The timeframe for the revalidation program. Dr Flynn advised she hoped that in three years, there would be a clear direction on revalidation. Any subsequent required changes to accreditation standards would include a bureaucratic process that would take time in addition to that.
- Enforcement of advertising guidelines. Dr Flynn noted that AHPRA has a statutory offences unit that handles complaints regarding advertising. The person in breach is written to, and if they refuse to desist, steps are taken towards prosecution.
- Where current CPD programs are falling down. Dr Flynn indicated that peer review and multisource feedback is important, as well as interaction with peers and the opportunity for each specialist to reflect on where they are going. Some Colleges do this more than others.
- Concerns about applying general revalidation standards to practitioners within very different areas of practice. Dr Flynn noted the need to have a system that is contextualised to scope of practice, including type/location of work. There is an emerging recognition about the risk of employing a one-size-fits-all approach.
- The opportunity for Colleges to inform any uniform approach to mandatory reporting, and in particular whether the Expert Advisory Group will take input from Colleges. Governments must decide on the mandatory requirements, and input from the sector, academic reports, and Colleges would be important. The Expert Advisory Group will focus on what is happening in Australia. The Consultative Committee will send out some information, commencing with a set of principles.
- A uniform process for assessing IMGs or an orientation program prior to embarking on accreditation in Australia. The idea was discussed at COAG several years ago. The MBA puts onus on the signed up supervisor. Guidelines have been developed for orientation, including those on the DoctorConnect website. The concern is that unless there is an incentive for IMGs to undertake these things – such as making it a requirement for accreditation – they will not be driven to take it up.
- Retaining people who are not comparable specialists. Rural areas are often happy to employ people who are not comparable, which provides risk to those areas.

### 2.6 Australian Indigenous Doctors’ Association

Dr Sean White addressed the report provided by AIDA, noting that Dr Kali Hayward had taken over from Dr Tammy Kimpton as President at the October Annual General Meeting.

Dr White thanked Colleges that provided support at the Annual Conference in October, and those who participated in the Growing Our Fellowship workshop.

The CPMC Indigenous Health Subcommittee has indicated strong support to increase Aboriginal and Torres Strait Islander medical professionals, noting that completion rates for medical schools remain a big issue. Many Colleges have still not had an Aboriginal or Torres Strait Islander trainee or Fellow.

AIDA is aware there are concerns about duty of care regarding the effect of dropping out of Fellowship on Indigenous trainees, and believes support is needed to assist with alternative pathways. Cultural care and access to mentors may need to be provided and possibly paid for by the medical college.

Dr White noted that AIDA should be part of that process to find out why so many trainees aren’t completing their training. With increased numbers of medical students coming
through schools, these problems are only going to increase in future years. AIDA encourages Colleges to meet with the registrars and discuss and workshop this problem. Feedback from registrars/members who are failing is critical.

Professor Hollands asked if there is a place for Indigenous trainees to have specifically appointed mentors to guide them through the training. Dr White noted there have been mentors in the past, and it is a good idea. However it depends on the person. The mentor must be someone who can relate to the trainee, and have some sort of connection.

While the Te ORA program in New Zealand (engaging families in training) has had some good statistical results in retaining Indigenous trainees, in New Zealand it is easier as there is one culture, and one language.

Professor David Watters noted that RACS has been planning to offer more mentoring for junior doctors in the future, as there has been advice that mentorship should begin before traineeship. A/Professor Frank Jones noted that RACGP has mentoring specifically for people at RACGP, with practice-based assessment to make the process more scientific and evidence-based.

Dr White also noted that many AIDA members come from disadvantaged backgrounds, and have been unable to complete traineeship and Fellowship exams due to external stresses.

Professor Hollands noted that the collaboration between AIDA and CPMC is working well, and that CPMC will continue to work to help more Indigenous doctors through training.

### 2.7 Australian Commission on Safety & Quality in Healthcare

Members noted Professor Villis Marshall was an apology for the meeting, and directed questions to the Chief Medical Officer, Professor Chris Baggoley.

Concern was raised about the Australian Atlas of Healthcare Variation (the Atlas) and the Colleges’ limited opportunities to provide feedback. In particular, members were worried about the way the data is being presented to the community.

Ms Anne Trimmer (AMA) met with Secretary of Health, Mr Martin Bowles on this issue, noting that the data analysis was probably good, but it needs to be contextualised upon release. Furthermore, any guidelines that result will need to allow flexibility for the particular doctor and patient.

Professor Michael Permezel (RANZCOG) expressed disappointment that Colleges were not consulted at an earlier stage, and noted it was concerning that commentators on the data had been hand-picked.

Professor Baggoley noted that the Atlas will be launched on 26 November.

### 2.8 Australian Medical Association

Ms Anne Trimmer, Secretary-General, spoke to the AMA written report. The AMA supports many of the reviews underway, but has noted that every announcement has been highly politicised and anti-doctor, without any need. The AMA has advised the minister that the messaging is putting the medical profession offside.
Ms Trimmer noted regarding the PSR review, that Compliance has moved from the Department of Human Services to the Department of Health.

The AMA’s biggest concern with the MBS review is the current mixed messaging about what will happen with items on the MBS. The Minister has said there is a ready capacity to replace removed items with new items, and referred to the three step approach to reviewing items tabled in the AMA’s written report. The AMA would like the clinical committees and working groups involved in the review to consult with Specialist Colleges.

Ms Trimmer discussed concerns about private health insurer behaviour. A review is underway, and the AMA reports that while the Government is not looking for any particular outcome from the review, the Minister has stated that there will be no role for private health insurance in primary care. There is no committee for this review, as there is with the primary care and MBS reviews. Submissions are due soon, with terms of reference to be announced today.

The AMA is also supportive of the intern review, and continues to be concerned about the Specialist Training Program (STP). Maldistribution continues to be an issue, and some time ago, the AMA put forward a proposal to Government for a community placement program to help address this.

Ms Trimmer acknowledged work of Chair, and welcomed the new Chair, noting Professor Talley had also undertaken the role of Editor in Chief to the Medical Journal of Australia.

2.9 Medical Deans Australia and New Zealand
Professor Nicholas Glasgow spoke to the report. MDANZ is continuing to work with RACS on bullying and harassment, and what can be done in medical schools.

MDANZ is also undertaking work on Inherent Requirements, that is, analysing things that are not teachable, but inherent. The group has developed an official statement guideline, however it recognises that it may need to be refined with use.

MDANZ is also involved in the professionalism work that the AMC is leading. There is a concern that professional attitudes and behaviours may not be able to be dealt with within university structures. Professor Glasgow provided the example of a student signing an absent friend into a tutorial, and not appreciating the importance of what a signature means for the medical profession.

The second summit meeting on clinical academic training was held on 11 November, and co-hosted with RACS. MDANZ looks forward to engaging all organisations in the CPMC Professions Forum.

In response to a question from Professor Watters (RACS) on whether universities are struggling to stop people with behavioural concerns from entering the profession, Professor Glasgow noted that deans can prevent such students from qualifying, but can have those decisions overturned on appeal. The alternative is to have courses where appropriate behaviour is a requirement, and universities are moving in that direction.
Professor Flynn noted that the MBA only has jurisdiction to interfere with a medical student if they have a criminal record, or an impairment that puts patients they are working on (during a placement) at risk.

Professor Glasgow noted that a minority of medical schools have a framework in place to address students exhibiting behavioural issues, Professor Watters noted that RACS is trying to teach professionalism, and expressed interest in working with MDANZ on this issue. Mr Frank noted that a working group, chair by David Elwood, is examining this issue and is hoping to work closely with medical schools.

In response to a question from A/Professor Lucie Walters (ACRRM), Ms Carmel Tebbutt agreed that there is a five-year trend that shows a reduction in rural students entering medical school. It is not known what is driving the trend, however the 25% rural recruitment target for Commonwealth Supported Places is being met nationally.

2.10 Confederation of Postgraduate Medical Education Councils
Members noted that the CPMEC Chair, Professor Richard Tarala was an apology, and Professor Hollands brought members’ attentions to the resolutions of the Australian Junior Medical Officers Committee.

2.10 Presentation by RACS President on EAG
Professor David Watters presented on the Expert Advisory Group on Discrimination, Bullying and Sexual Harassment. Following the presentation, discussion ensued.

Professor Brad Horsburgh noted that RANZCO had undertaken a similar questionnaire to RACS, and found that Fellows had experienced a similar level of bullying and harassment. RANZCO is formulating its action plan, before issuing an apology. Professor Michael Cleary noted that RACMA had also undertaken a survey, and it is on the board’s agenda currently.

In response to a question from Professor Bala Venkatesh (CICM) on follow up actions, including mechanisms for reporting to the medical board, Professor Watters indicated that RACS will report behaviour that is criminal or requires the individual to leave their Fellowship. When people are censured by RACS, their names will be reported on the RACS website. RACS is anticipating a large increase in complaints once the complaints system is fixed. The aim is to have silent bystanders break their silence. A follow-up survey will occur in the future.

Dr Genevieve Goulding (ANZCA) asked about the impact of removal of Fellowship, noting it to be more a reputational risk rather than actually affecting the doctor’s ability to practice. Dr Flynn stated that the MBA cannot remove someone from the medical register without completing a disciplinary process. The MBA also cannot remove specialist registration because the College has removed their Fellowship. Dr Catherine Yelland (RACP) noted that the doctor’s supervision ability would be lost.

Professor Glasgow queried which organisation would be responsible when a medical student experiences unprofessional behaviour in multiple settings, noting the legal issues surrounding this, such as privacy and natural justice. The ramifications of losing a court case as a result of breaching a law would also need to be considered.

Further concerns on professionalism were raised, including:
• The concern that private hospitals may not report unprofessional behaviour of surgeons if they risk losing them.
• That since 2000, there has been a change in the attitude of private hospital groups, however they still need to be totally committed to removing doctors who do not improve.
• The impact of unprofessional behaviour on nurses, given the power relationship between surgeons and nurses being much greater than surgeons and registrars.
• The importance of trainees responding to AMC surveys
• The changing environment in Australia surrounding abuse, particularly given the national inquiry into sexual abuse of children in institutions.
• The need for the perpetrator to understand what they are doing. They have to want to change.
• RANZCP now permanently suspends Fellowship if the Fellow is found guilty of a boundary violation.
• Professor Permezel (RANZCOG) suggested early intervention, including the introduction of a program to instil the necessary professional qualities in the first two postgraduate years. Professor Jones (RACGP) indicated this should happen during a medical degree, and educators in charge of those degrees may have not undertaken an adult learning program. If structural changes are initiated, then the culture can gradually change.

Professor Hollands noted there will be opportunities about how the CPMC can engage with health community on this.

Professor Hollands thanked the group for the last few years.
GOVERNANCE

1.1 Minutes of previous meeting held 6 August 2015
The minutes of the previous meeting held 6 August 2015 were moved for acceptance by A/Professor Walters (ACRRM) and seconded by Professor Watters (RACS).

1.2 Business arising from the minutes
No business arose from the minutes.

1.3 Chair’s Report
Professor Talley noted that Professor Hollands had provided the Chair’s report earlier in the meeting, and that he would provide a detailed report at the next meeting.

1.4 Chief Executive Officer’s Report
Ms Magarry provided and spoke to a written report on the activities which have occurred since the last meeting of Directors. The CPMC has tried to engage and develop relationships with the Minister for Health, Aged Care and Sport, the Hon Sussan Ley MP, and her assistant ministers Senator Fiona Nash and the Hon Ken Wyatt AM MP. The Secretaries Luncheon was successful, as well as the CPMC CEOs meeting on 11 November, which Departmental officials Ms Penny Shakespeare and Ms Sharon Appleyard attended.

Ms Magarry discussed the current monthly newsletter from CPMC, noting that its public release could help CPMC’s communication strategy. Members agreed that any issues regarding its public release would be directed to Ms Magarry.

Discussions between the Department and CPMC have taken place regarding the continuation of a rural health program. The RHCE Program will not continue beyond 2016, however the Department has asked CPMC to develop a proposal relating to direct grants for rural specialists. The proposal cannot include project grants for Colleges or be branded as RHCE. Members noted that it may be possible to continue to use the RHCE website, as the domain name is www.ruralspecialist.org.au rather than having RHCE in the title.
Ms Magarry and RHCE Program Manager, Mike Davidson, will draft a proposal in the coming weeks. If Colleges have feedback on this idea, it can form part of proposal.

1.5 Financial Statements and Report
The financial statements and report had previously been addressed, and no further discussion was forthcoming from members.

1.6 Changes in Directors
The former Chair noted changes in directors earlier in the meeting.

1.7 Other Governance Matters
Professor Talley addressed the committee, raising the topics of structure, function and communication strategy. Discussion ensued with members agreeing to the following:

Structure
Members agreed that
- CPMC should form an executive, with the Chair elect and up to four others, to be trialled for one year. When executive members resign, they will be replaced by
another CPMC member (not just their replacement). Others issues discussed, included having a past president on the committee for continuity, and having an executive with a mix of opinions as more important than which College they are from. Professor Talley will move forward with forming an executive.

- CPMC should continue to meet four times a year.
- A CPMC member should be appointed as a lead for each section of the Professions Forum. Expressions of interest were received from A/Professor Walters for the Chief Medical Officer’s Report, and A/Professor Michael Cleary for the AHPRA report. Professor Goulding noted that questions about each report could be fielded to its nominated lead at the dinner the night prior to each meeting. Members were asked to contact Professor Talley if they are interested in taking a lead at the next meeting.

- Guests will continue to be invited.
- CPMC will continue to follow up and seek answers to questions raised during the meeting. The prospect of the Chair writing to guests after each meeting to highlight the issues was discussed.
- The prospect of rotating CPMC meetings through Colleges, or meeting in Canberra will be discussed at the next meeting.
- The use of a round table rather than a long one will be considered.
- Sign off procedure needs to be discussed further, to ensure that Colleges agree with statements issued by the Chair on behalf of CPMC.

- Each meeting will have 1-2 presentations from Colleges on topical key issues. It was suggested that each College should do a presentation at least once every two years. The next CPMC meeting topic will be Workforce Planning. Professors Venkatesh and Hopwood volunteered to present as Members agreed there should be one presentation from an oversupplied College and one from an undersupplied College. Professor Talley noted that these presentations will communicate to other stakeholders that CPMC and Colleges are a long way forward in addressing these issues. This will help Colleges lead discussions rather than having other solutions imposed upon them, such as by AHPRA regarding revalidation.

- Other presentation topics tabled in the meeting included dual training; how well Colleges conduct appeals processes within education; and why Indigenous GP trainees are failing to complete their training – although it was noted that this last topic is sensitive and perhaps CPMC should be looking sector-wide on this issue rather than presenting on it.

**Action:** Professor Nicholas Talley to progress the formation of a CPMC Executive.

**Action:** All Presidents are invited to nominate to lead discussion on a section of the Professions Forum section of the next CPMC meeting.

**Action:** Professors Bala Venkatesh (CICM) and Malcolm Hopwood (RANZCP) to prepare a presentation on Workforce Planning from their College perspectives.

**Action:** All Presidents are invited to nominate to present on Workforce Planning at the next meeting.

**Function**
- Members agreed CPMC should focus on 2-3 major subject areas in addition to normal business.
• Issues raised where CPMC could potentially be more effective than individual Colleges, included revalidation, scope of practice, professionalism, leadership in medical training pathway integration, maldistribution, lobbying to government, tensions around advocating to health workplaces, working conditions, putting pressure on hospitals, and accreditation.

• Rather than a retreat, members agreed to have a strategic planning session on the afternoon prior to the next CPMC meeting in February. CEOs will be part of the meeting, and Professors David Watters and Bala Venkatesh will be on the planning group for this session. It was proposed that two Colleges will present on revalidation, with RACP and RCPA suggested.

**Action:** Strategic Planning Group (Professors Talley, Watters and Venkatesh) to plan Strategic Planning Session on the afternoon prior to the next CPMC meeting in February.

**Action:** Dr Catherine Yelland (RACP) and A/Prof Peter Stewart (RCPA) prepare presentations on revalidation.

**Communication Strategy**

• Members discussed the prospect of CPMC submitting articles to regular College publications, and media releases, profiling good work done by other Colleges, such as RACS’ leadership on bullying and harassment. This idea was broadly supported.

• Members also discussed the prospect that the Chair should take on the role of writing an article for medical journals.

Members also discussed potentially surveying Fellows to ask what issues CPMC should consider leading, however it was unclear how well Fellows could gauge CPMC’s capacity. The potential for governments to replace medical Colleges with another specialist teaching model was also discussed, and the need for Colleges to promote their reputation and name to help address this threat.
2. SUB-COMMITTEE REPORTS

2.1 Education Subcommittee (in abeyance)
Professor Talley noted that the Education Subcommittee is in abeyance. Professor Permezel indicated the group was lacking an agenda, but had completed some useful work, for example on supporting Indigenous Women.

2.2 Indigenous Health Subcommittee
Professor Talley raised the prospect of restructuring the governance of the Indigenous Health Subcommittee. Professor Hopwood noted that the Australian Indigenous Doctors’ Association (AIDA) want to combine a number of agreements in place with CPMC, CPMEC and others. The proposed changes would not change CPMC’s relationship with AIDA and would not stop Colleges having relationships with AIDA. They would, however, allow for broader opportunities to develop. Given CPMC quorum was not reached at this stage of the meeting, Professor Talley noted that CPMC will circulate the issue of proposed restructure out of session.

Action: CPMC to circulate to members the issue of a proposed restructure of the Indigenous Health Subcommittee for approval

3. REPRESENTATIVES REPORTS FOR NOTING

3.1 National Medical Training Advisory Network
The members noted the update from the Department in the Chief Medical Officer’s reporting concerning NMTAN.

3.2 Independent Hospitals Pricing Authority (IHPRA) Stakeholder Advisory Committee
Members noted no meeting had taken place since the last CPMC meeting.

4. STRATEGY

4.1 Revalidation – Regulation Policy
Members noted the report.

4.2 Review of Medicare Benefits Schedule
Members noted the report.

4.3 Review of the Specialist Training Programme
Members noted the report.

4.4 Review of Membership Subscriptions – Report from Working Group
Ms Magarry delivered an update from the working group on behalf of Ms Debra Graves who had to leave the meeting early.

Ms Linda Smith (RACP) noted that a number of College CEOs had discussed member subscription. RACGP was concerned it is paying the largest amount, and would like a cap on the total fees.
Colleges agreed on the existing fees for the next 12 months.

David Andrews (RANZCO) raised the issue of why CPMC is attempting to make surpluses. Professor Talley noted that a year ago, CPMC was just solvent, and that the financial situation has improved since then. Professor Venkatesh (CICM) reminded members that RACS incurred a large cost for the Expert Advisory Group on Bullying and Harassment, and CPMC requires a buffer in the case of a potential legal bill. Discussion ensued about what is considered a normal buffer, with some members believing CPMC having the ability to pay staff, without any other fees, for 12 months. Others believed two years was usual.

Other concerns raised included the potential for Colleges to contribute on top of annual fees on a case by case basis; how a big reserve is returned fairly to Colleges if CPMC is dissolved; why there has been a 10% increase in the budget for next year; and if there should be a CPI increase to the CPMC budget each year.

Professor Talley noted that CPMC will provide a budget for the February CPMC meeting, and discuss and address the above issues then.

4.5 Submissions: Skilled Occupation List
Members noted the Chair’s correspondence to the Department of Industry regarding the Skilled Occupation List. Professor Hopwood noted that RANZCP has put in a submission to retain psychiatry on the list. Ms Magarry confirmed that was included in the CPMC submission to the Department as well.

5. OTHER BUSINESS

5.1 CMC New Zealand Report
Members noted the Council of Medical Colleges of New Zealand Report. CPMC will issue a report from meetings also.

5.2 AMC Nominee for the Specialist Education Accreditation Committee (SEAC)
Ms Magarry advised members that the CPMC nominee for SEAC will go out for a response within two weeks.

5.3 RACGP – ANU project proposal
Professor Frank Jones (RACGP) raised a project proposal from the Australian National University that is seeking financial support from CPMC. The project is about doctors looking after doctors who have been abused.

Members agreed to not support the project. Reasons included that CPMC should not be endorsing a research project; the project is outside CPMC’s remit; it would start a precedent; and concerns that the project would be a duplication, and would not support what RACS is trying to do.

5.4 Meeting Evaluation
The meeting did not undertake an evaluation.

6. DATES FOR 2016
Members noted that dates for 2016 were determined at the last meeting.

Professor Talley brought the meeting to a close at 2:20
Committee of Presidents of Medical Colleges

Actions Arising from the 112th meeting of the Committee of Presidents of Medical Colleges held at on Thursday 12th November 2015 at the Royal Australian College of General Practitioners, 12 Mount Street, North Sydney

Action Item

**Professions Forum 2.3**

<table>
<thead>
<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Action: Follow up with Dr Andrew Singer to receive a response from the Department on the final submission that utilised College input to Health Workforce Division for health workforce projections</td>
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**Governance: 1.7**

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<td>Planning Group – including Professor Talley, Professor David Watters, Professor Bala Venkatesh</td>
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<tr>
<td>Action: Prepare presentations on revalidation for Strategic Planning Session</td>
<td>Dr Catherine Yelland (RACP), A/Prof Peter Stewart (RCPA)</td>
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**Strategic Business Session: 2.2**

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<th>Action</th>
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<td>Action: Circulate to members the issue of a proposed restructure of the Indigenous Health Subcommittee for approval</td>
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**Strategic Business Session: 5.2**

AMC Nominee for the Specialist Education Accreditation Committee (SEAC)

| Action: Circulate the AMC request for nomination to SEAC | CPMC |
## Actions Arising from the 112th meeting of the Committee of Presidents of Medical Colleges held at on Thursday 12th November 2015 at the Royal Australian College of General Practitioners, 12 Mount Street, North Sydney

### Action Item (tick showing done or notation made)

#### Professions Forum 2.3

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<td>He will advise in Dept report</td>
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<td>Dr Catherine Yelland (RACP) ✓</td>
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<td>A/Prof Peter Stewart (RCPA) ✓</td>
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#### Strategic Business Session: 2.2

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<td>Action: Circulate to members the issue of a proposed restructure of the Indigenous Health Subcommittee for approval</td>
<td>Preference to hold over to Feb meeting</td>
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#### Strategic Business Session: 5.2

**AMC Nominee for the Specialist Education Accreditation Committee (SEAC)**

<table>
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<th>Action</th>
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<tr>
<td>Action: Circulate the AMC request for nomination to SEAC</td>
<td>Prof Permezel elected</td>
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Committee of Presidents of Medical Colleges

Executive Meeting

Minutes

Held by teleconference Friday 18<sup>th</sup> December, 2015

1. Welcome and Introductions

Professor Talley opened the meeting by teleconference at 3:30pm and welcomed the following Directors:

- Professor David Watters, President the Royal Australasian College of Surgeons
- Professor Bala Venkatesh, President, the College of Intensive Care Medicine
- Dr Frank Jones, President the Royal Australian College of General Practice

In attendance: Ms Angela Magarry, Chief Executive, CPMC and Company Secretary

1.1 Apologies Received

Apologies were received from Professor Catherine Yelland who was on leave.

Professor Talley noted a teleconference had also been convened with Dr Brad Horsburgh, President the Royal Australasian College of Ophthalmologists and member, CPMC Executive on Monday 14<sup>th</sup> December which followed the same structure as the 18<sup>th</sup>. The notes from that discussion are included in these minutes where appropriate.

2. CPMC meeting structure

The current structure of the CPMC quarterly meetings was discussed in the context of ensuring good governance and enhancing the content. There was general agreement that retaining the evening dinner and morning forum was appropriate as the network and engagement with stakeholders was beneficial, however the current line-up of presenters left limited time for new information or discussion. Dr Horsburgh suggested a change in the order of preference reflecting the importance of issues would be appropriate and could be driven via the Chair selecting the order based on reports provided.

All Directors agreed that it was ‘good governance policy’ for an in-camera session to occur without the CEOs including part without the CPMC CEO.

A discussion on including the Australian Medical Association President in a separate session solely with Colleges occurred. While it was considered appropriate for the AMA President to address a meeting of College Presidents only and have a discussion on issues such as the MBS review and general structural funding reviews by government, there was a concern the AMA President had not attended any meeting of CPMC for some time.

The Executive agreed to invite the Vice-President and CEO to the February meeting. (Ms Magarry)

3. Presenting Organisations

A discussion occurred in relation to inviting other organisations of interest to the strategic agenda of CPMC occurred and three organisations were raised: the Australian Academy of Health & Medical Sciences, the National Medical Training Advisory Network; and the Primary Health Care organisation.

Directors agreed the invitation should be extended to the AAHMS to attend the Morning Forum starting from the February meeting if possible.
Committee of Presidents of Medical Colleges  

Executive Meeting  

Directors agreed that the CPMC representatives on the NMTAN had sufficient information to brief the CPMC group in the strategic issues session rather than have the NMTAN representative from government given the confidentiality provisions surrounding any advice they could provide.

Directors agreed to keep a watch on the progress of the PHOs so that in future a representative from this important grouping could be invited to brief Directors on their overarching role, responsibility and fund holding capacity.

4. CPMC Financial Budget 2015-16

Directors were provided with the budget as reflected in the profit and loss accounts for the period ending November 2015, the monthly statement and the balance sheet. Directors noted that all appeared in order and CPMC was solvent. Ms Magarry advised that in December some movement of funds occurred between the RHCE grant account to the CPMC operating account to reflect the charge-back capacity to fund the National Director role occupied by the CPMC CEO. Ms Magarry advised that in January as part of Phase 2 of the IT restructuring process commenced in 2013, CPMC would receive support from ANZCA under the MOU to provide a capital upgrade and management service. In January CPMC would also be liaising with the accountant to undergo the auskey process now required of all businesses to interact electronically with the Australian Tax Office.

Directors approved the financial statements.

5. Political Engagement

Directors were advised of the opportunity to participate in a government relations day to Canberra on Thursday 4th February 2016 and discussed the issues. Professor Talley extended the invitation to attend and this was accepted by Professor Bala Venkatesh, Professor David Watters, Dr Brad Horsburgh with a check of Dr Yellands availability. The travel would be at the individual’s expense.

Commencing at 9am at Parliament House members of the CPMC Executive would meet with The Hon Catherine King, Opposition Spokesperson on Health followed by a meeting with The Hon Sussan Ley, Health Minister. Afterwards travelling by cab to meet with Secretary Bowles and Professor Baggoley before travelling out to Majura to meet with the Australian Medical Council. The schedule would anticipate departing Canberra by 3pm.

Directors discussed the issues to be developed up into a briefing page for each member and also distilled into a briefing note for provision to the relevant meeting contact. These were listed as follows:

- Health Care Reform generally with a particular focus on the MBS Review;
- Medical Training Issues including support for the STP program, workforce distribution including data gathering and planning
- End of Life Care including an advanced care directive campaign.

On this matter Professor Talley advised that while there was no CPMC policy it was an issue which required development. Professor Venkatesh informed the Executive that CICM had already undertaken some policy work on this matter. Dr Frank Jones advised that this matter is becoming important for general practice especially in the context of prescribing and also in the management of elderly people. Professor Watters advised that as most Colleges had undertaken some policy work on this matter and given there was no policy formulated by CPMC it would be
useful to obtain the relevant existing statements to determine what current thinking was. He also indicated that this was an area for which the new ‘RHCE’ program might focus on.

Dr Frank Jones mentioned the existence of the Physician Assist network and to take their work into consideration as well. Ms Magarry to undertake the development work.

- Support for medical research including expanding clinician led research opportunities;
- Indigenous Health;
- Medicinal cannabis

On this matter Professor Talley confirmed that there was no policy yet formulated on this health issue and that given doctors will be closely involved in whatever policy process is established it would be useful to find out the Ministerial view. Professor Watters informed the Executive that the RACS statement closely aligns with ANZCA. Dr Jones advised that the RACGP had a view and would provide that. All agreed that there were potential issues associated with developing a health policy on this matter and to begin with CPMC should gather the position papers in existence and especially where convergence of ideas exist.

Ms Magarry to develop this process.

6. CPMC Planning Session

Directors were advised that the planning session would occur on Wednesday 17th February from 1pm at the RCPA in Surry Hills with the agenda under development but following along the lines of an overview of the health system, challenges, workforce and issues for CPMC to pursue in 2016 as part of the advocacy, policy and government relations agenda.

The Executive agreed that the planning session was critical to the formulation of issues for pursuit through CPMC and supported the consideration of obtaining a co-facilitator. Ms Magarry advised of Dr Kim Webber having the expertise and respect in the field of health workforce and who is available.

Ms Magarry to develop the agenda and distribute for input from the Executive.

7. Other Business

Professor Bala Venkatesh raised an issue relating to governance and the length of time on the Executive plus continuity beyond. Professor Talley explained the provisions in the current Constitution relating to College Presidents only on the CPMC and any Executive.

Professor Watters supported the existing structure of College Presidents on the Executive. Dr Jones supported this and raised the issue of continuity as important for corporate memory purposes.

Professor Talley agreed to take the matter to the CPMC meeting under governance.

Ms Magarry confirmed the requirement for minutes to be taken of CPMC Executive meetings and to be circulated accordingly.

The Executive meeting finished at 4:30pm. Actions list overleaf FYI

Executive-in-Confidence
### ACTIONS LIST

<table>
<thead>
<tr>
<th>Item</th>
<th>Issue agreed or actionable</th>
<th>Person responsible</th>
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<tbody>
<tr>
<td>2</td>
<td>Alter CPMC structure &amp; separately invite the AMA Vice-President to attend and address the group</td>
<td>Angela</td>
</tr>
<tr>
<td>3</td>
<td>Extend invitation to AAHMS to attend Morning Forum</td>
<td>Nick/Angela</td>
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<tr>
<td>5</td>
<td>Political Engagement Day agenda circulate to Executive for information</td>
<td>Angela</td>
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<tr>
<td></td>
<td>Develop up issues &amp; circulate to exec for input</td>
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<td>Briefing note circulation to meeting contacts</td>
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<tr>
<td>6</td>
<td>Planning Session/retreat – develop up the agenda and circulate to Executive for input</td>
<td>Angela</td>
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<tr>
<td></td>
<td>Lock in Dr Webber for the co-facilitation and liaise with her regarding process and write up</td>
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<tr>
<td>7</td>
<td>Other Business: Governance and the executive</td>
<td>Angela</td>
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<tr>
<td></td>
<td>Take a paper to the next CPMC meeting on the construct of the Executive and provision for continuity including elections and process</td>
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Executive Meetings 4 February 2016

Members of the CPMC Executive comprising CPMC, RACP, RACS, RANZCO, CICM met in Canberra for a day of interaction with Parliamentarians and senior officials, as well as the Australian Medical Council.

As a result of a general discussion with reference to the comprehensive briefing papers provided to the Executive prior to the meeting there was agreement that where possible, each of the issues would be raised, as well as the following:

- What is the opposition’s policy on health care?
- Reinforce support for the MBS review;
- Refugee health and asylum seeker health;
- STP funding;
- Medical student numbers and suggesting a cut of 10-15% to CSP;
- Importance of clinician research and the link to STP;
- Seeking their views on obesity and end of life care; and
- Support for the Australian Trauma Registry.

General actions from the day included:

- Angela to send around the Senate Reference to Medical Complaints Inquiry and add that to the CPMC agenda and also discovering any other information in relation to that issue;
- Angela to add an agenda item on crafting a CPMC statement on refugee health;
- Add the Private Health Insurance review to the CPMC agenda for general opinion and commentary in relation to apparent obligations on surgeons by certain funds to require them to sign a declaration.

Meetings held

The Hon. Catherine King MP who had advisers speak to the Executive due to divisions, and the following issues were discussed:

- The GST enquiry is occurring and there is discussion about developing a hospital benefits schedule so that GST percentages go to hospitals;
- Senate Estimates hearings are next week and they will ask a question about the scope of the MBS review and the STP
- They are concerned about the PHI review and possibility of reducing the number of funds.
- Ms King was concerned about the importance of preventive health and was supportive of a health promotion strategy.

Action: Question to be asked in Estimates concerning the status of the STP, crafted and dealt with by the Opposition office.

The Hon. Sussan Ley Minister for Health focussed on support for regional, rural and Indigenous health services and delivering a more efficient health system. The CPMC Chair flagged concerns in relation to STP; the number of medical students, the Skilled Occupation List still holding all
specialties in under supply and the support for the MBS Review with any savings to be reinvested into health.

The Minister said she would follow up with the Department about the 29% pass rate for psychiatry. The Minister acknowledged the challenge of dealing with the large number of medical graduates, how these flow into the pipeline and CPMC’s suggestion to cap the number of CSP places. She mentioned the benefits of training in rural and regional Australia and all College Presidents indicated this already occurs. Some examples were given. The National Obesity campaign was supported by the Minister as a good example of proactive engagement by health professionals. The proposal for a project addressing End of Life Care was noted as with the Minister.

**Action:** CPMC to write to the Minister with thanks and including any issue not directly discussed and Minister Ley to be invited to address Presidents 2 June, 2016.

**Health Secretary Martin Bowles** advised the Executive of the imperative to ensure continuity in the policy discussion so that there is no disruption to reform processes because of political change. A discussion occurred in relation to the STP concern and members were advised of the Department’s intent to not diminish numbers. The process is being conducted by KPMG. There was a discussion concerning workforce and the SOL plus the NMTAN modelling would be revised to reflect 50% of the immigration rate.

**Action:** Invite Mr Bowles to address the 2 June 2016 meeting of CPMC.

**Australian Medical Council** meeting was attended by Mr Ian Frank, CEO, Ms Jane Porter, and Deputy CEO Ms Theanne Walters. Discussion covered the issues of mutual concern in relation to regulatory policy for example the latest NRAS Review, the challenges of managing a protection of title model rather than a scope of practice. The Senate Enquiry was discussed with the AMC citing the process was broad ranging and started as a data retention issue request by AHPRA for Senator Madigan and a general medical complaints concern by Senator Xenophon.

The AMC standards on maintaining trainee wellbeing was discussed in the context of the new standards. The UK experience in relation to trainee wellbeing was discussed with the annual trainee survey used by the General Medical Council cited as useful and feeds into accreditation process. On the issue of complaints handling there was a discussion about the merit of independent review and concerns held by Colleges regarding the impact on insurance from complaints.

The selection into training and subsequent range of appeals, complaints and potential other risks was discussed in the context of the development of the National Testing Centre and potential for Colleges to utilise this facility for part of their processes to ensure the system was fair and of good standard.

**Action:** Develop up the discussion surrounding trainee wellbeing in the context of the CPM Meeting.
Item 5.4: Chief Executive Officer’s Report

Since the November CPMC meeting the secretariat has followed up on the actions arising from the meeting in general, and commenced preparation for the various meetings scheduled for February 2016.

- Progressing the formation of a CPMC Executive and convening the first teleconference between the Chair and members of the Executive (RACS, RACP, CICMANZ, RACGP, RANZCO) as available. The minutes from that meeting are provided.
- Scheduling a Government Relations Day on 4th February 2016 for the Executive with the following participants: The Hon. Catherine King (shadow Health Minister); The Hon. Sussan Ley (Health Minister); Mr Martin Bowles (Health Secretary); Professor Chris Baggoley (CMO); Ms Theanne Walters, DCEO Australian Medical Council. Preparation of briefing notes and biographies in relation to the above participants and members of the CPMC Executive.
- Research and policy development to prepare a series of background papers covering:
  - Health care reform generally with a particular focus on the MBS review to discuss the sustainability of the Australian health care system;
  - Medical training issues including support for the STP, workforce distribution including data gathering and planning;
  - End of life care including advanced care directives campaign;
  - Support for medical research including expanding clinician led research opportunities;
  - Indigenous health;
  - Medicinal Cannabis from the perspective of an update on legislation and implications from regulation for medical practitioners;
  - Australian Trauma Registry – progressing support for the continuity given the extension of support by the Australian government internationally.
- Preparation of the logistics and background papers to support the MBS Review meeting held 9th February at RACP between College members and the MBS Chair, Professor Bruce Robinson.
- Preparation of the 17th February strategic planning forum encompassing formulation of papers, establishing a planning group, locating a facilitator including liaison with the logistics team at RCPA.
- Preparation of a communications strategy to report against at CPMC meetings
- Managing the RHCE program encompassing the finalisation of Funding Round 7 projects, payments, acquittals, and managing phasing into wind-down.
- Managing the Program Management Unit staff- liaising with the RACP CEO and Commonwealth concerning extending the arrangement to wind-down RHCE and provide for transitional arrangements.
- Preparation of a proposal submitted to the Commonwealth for a possible funding agreement linked to the STP to be called Support for Rural Specialists in Australia and focussed on individual grants. This was approved by the Chair.
- Meeting with various advisers and College policy advisors on issues, agenda and logistics.
• Meeting with Qantas national sales director and regional manager concerning performance targets and the management of the agreement. This agreement covers the period 2014-2018. The discussion included negotiating better fares for domestic and international routes and communicating with the Colleges accordingly (information to be sent separately).
• Preparation of accounts reflecting the end of December, 2015 (Quarter 2) and reporting against variance.
• Liaising with the accountant concerning the preparation for CPMC to move to Auskey arrangement for taxation compliance- this will take time.
• IT phased upgrade in January via service agreement with ANZCA under the rental MOU.
• General administrative arrangements to support the 18th February Board meeting and dinner.
• AHPRA Professions Reference Group meeting development with Chair of the PRG
• Meeting with Ministerial adviser to Sussan Ley 12th February.
• Presidents to note that I was appointed to the Board of the Australasian College of Health Service Managers in December 2015. There are no conflicts of interest.
5.5 CPMC Financial Statements

CPMC closed the first half of the financial year with the following cash at bank:

- Westpac operating account  +$79,961.39
- Westpac Maxi account     +$196,305
- RHCE                      +$301,026.97

CPMC is solvent and can pay its bills. CPMC is managing the development of reserves to ensure sustainability and projections show approximately $120K at end financial year 2015-16 and this is consistent with the risk management plan agreed in November 2013.

Attached is the CPMC Balance Sheet as of December 2015 and Profit and Loss for July-December 2015.

**Income:** CPMC income from subscription fees, sitting fees and management fees are all accounted for the financial year and no additional income expected. There may be potential income from a new funding agreement for rural specialists but this will not be known until March at the earliest.

**Expenditure:** CPMC is tracking well against the budget. Some variance in travel related expenditure due to advance commitments showing in the December quarter for February travel (Chair and CEO) as well as reimbursing the former Chair for operational expenses incurred as part of his role.

In January 2016 as part of the IT phasing an upgrade occurred to the IT equipment via service agreement with the host ANZCA, previously approved in 2014. This will cost CPMC approximately $3K in new equipment. CPMC has amortised the old equipment.

The Chair has advised that a reasonable budget buffer should be 6 months operating expenses held in reserves. CPMC operating budget is $280K and so holding $140K in reserves is within scope of the Chair’s requirements.

**Recommendation:** The financial statements be noted for the period ending 31 December 2015.
### Profit & Loss [Budget Analysis]

**July 2015 To December 2015**

<table>
<thead>
<tr>
<th>Selected Period</th>
<th>Budgeted</th>
<th>Result</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscription fees</td>
<td>$266,864.13</td>
<td>$265,400.00</td>
<td>$1,464.13</td>
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<tr>
<td>Sitting Fees</td>
<td>$2,058.00</td>
<td>$1,000.00</td>
<td>$1,058.00</td>
</tr>
<tr>
<td>Project Mgmt from RHCE</td>
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<td>$20,000.00</td>
<td>$5,000.00</td>
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<tr>
<td>RHCE Grant Funds</td>
<td>$806,302.11</td>
<td>$806,302.00</td>
<td>$0.11</td>
</tr>
<tr>
<td>Interest Received</td>
<td>$3,718.85</td>
<td>$5,000.02</td>
<td>$1,281.17</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>$1,103,943.09</td>
<td>$1,097,702.02</td>
<td>$6,241.07</td>
</tr>
</tbody>
</table>

| **Expenses** |          |        |              |
| Accountancy | $5,020.00 | $5,190.00 | $170.00 | (3.3)% |
| ASIC fees | $75.00 | $75.00 | $0.00 | 0.0% |
| Bank fees | $80.46 | $136.00 | $55.54 | (40.8)% |
| Computer Expenses | $714.00  | $1,200.00 | $486.00 | (40.5)% |
| Conference Fees | $90.00 | $600.00 | $510.00 | (85.0)% |
| Website Platform Design and Development | $3,000.00 | $2,400.00 | $600.00 | 25.0% |
| Legal Fees | $0.00 | $2,520.00 | $2,520.00 | (100.0)% |
| Meeting Expenses | $7,800.79 | $10,200.00 | $2,399.21 | (23.5)% |
| Office Supplies | $614.46 | $200.00 | $414.46 | 207.2% |
| Professional Development | $0.00 | $1,800.00 | $1,800.00 | (100.0)% |
| Rent | $0.00 | $5,100.00 | $5,100.00 | (100.0)% |
| Salaries | $76,813.14 | $67,776.00 | $9,037.14 | 13.3% |
| Superannuation | $5,365.58 | $6,780.00 | $1,414.42 | (20.9)% |
| Teleconference Expenses | $0.00 | $600.00 | $600.00 | (100.0)% |
| Telephone | $1,483.72 | $300.00 | $1,183.72 | 394.6% |
| Workcover | $1,952.18 | $1,608.00 | $344.18 | 21.4% |
| Travel |          |        |              |
| Accommodation | $11,797.19 | $7,500.00 | $4,297.19 | 57.3% |
| Airfares | $16,604.27 | $10,200.00 | $6,404.27 | 62.8% |
| Parking | $740.26 | $600.00 | $140.26 | 23.4% |
| Taxis | $2,916.48 | $1,200.00 | $1,716.48 | 143.0% |
| Other Travel Expenses | $1,132.07 | $900.00 | $232.07 | 25.8% |
| **Total Travel** | $33,190.27 | $20,400.00 | $12,790.27 | 62.7% |
| **Insurance Expenses** |          |        |              |
| Business Insurance | $0.00 | $1,800.00 | $1,800.00 | (100.0)% |
| Pro Indemnity Insurance | $0.00 | $1,800.00 | $1,800.00 | (100.0)% |
| Public Liability Insurance | $0.00 | $1,800.00 | $1,800.00 | (100.0)% |
| **Total Insurance Expenses** | $0.00 | $5,400.00 | $5,400.00 | (100.0)% |
| **RHCE Grant Expenses** |          |        |              |
| Funding and Management Fees | $544,868.61 | $0.00 | $544,868.61 | NA |
| **Total Committee of Presidents** | $681,068.21 | $132,285.00 | $548,783.21 | 414.8% |
| **Total Expenses** | $681,068.21 | $132,285.00 | $548,783.21 | 414.8% |
| **Operating Profit** | $422,874.88 | $965,417.02 | $542,542.14 | (56.2)% |
| **Total Other Income** | $0.00 | $0.00 | $0.00 | NA |
| **Total Other Expenses** | $0.00 | $0.00 | $0.00 | NA |
| **Net Profit/(Loss)** | $422,874.88 | $965,417.02 | $542,542.14 | (56.2)% |
**Committee of Presidents of Medical Colle**
6/14 Napier Close
Deakin  ACT  2600
ABN: 46 101 213 478
Email: ceo@cpmc.edu.au

**Balance Sheet**
**As of December 2015**

<table>
<thead>
<tr>
<th>Assets</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Bank Accounts</td>
<td></td>
</tr>
<tr>
<td>COP: Westpac Cheque 42-3262</td>
<td>$79,961.39</td>
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<tr>
<td>COP: Westpac Maxi 42-3588</td>
<td>$196,305.00</td>
</tr>
<tr>
<td>RHCE AC 688025</td>
<td>$301,026.97</td>
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<tr>
<td><strong>Total Bank Accounts</strong></td>
<td><strong>$577,293.36</strong></td>
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<tr>
<td>Clearing Accounts</td>
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<tr>
<td>Other Asset</td>
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<tr>
<td><strong>Total Clearing Accounts</strong></td>
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<tr>
<td>Other Current Assets</td>
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<tr>
<td>Paid in Advance</td>
<td>$7,895.19</td>
</tr>
<tr>
<td><strong>Total Other Current Assets</strong></td>
<td><strong>$7,895.19</strong></td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>$590,706.17</strong></td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$590,706.17</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
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</tr>
<tr>
<td>GST Liabilities</td>
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</tr>
<tr>
<td>GST Collected</td>
<td>-$0.47</td>
</tr>
<tr>
<td>GST Paid</td>
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<tr>
<td><strong>Total GST Liabilities</strong></td>
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<tr>
<td>Other Current Liabilities</td>
<td></td>
</tr>
<tr>
<td>Trade Creditors</td>
<td>$4,721.00</td>
</tr>
<tr>
<td>Provision for Long Service Lea</td>
<td>$5,297.63</td>
</tr>
<tr>
<td><strong>Total Other Current Liabilities</strong></td>
<td><strong>$10,018.63</strong></td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>$10,018.64</strong></td>
</tr>
</tbody>
</table>

| **Total Liabilities** | **$10,018.64** |
| **Net Assets**        | **$580,687.53** |

<table>
<thead>
<tr>
<th>Equity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Earnings</td>
<td>$139,345.87</td>
</tr>
<tr>
<td>Current Year Earnings</td>
<td>$422,874.88</td>
</tr>
<tr>
<td>Historical Balancing</td>
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<tr>
<td><strong>Total Equity</strong></td>
<td><strong>$580,687.53</strong></td>
</tr>
</tbody>
</table>

This report includes Year-End Adjustments.
**Item 5.6 Changes in Directors**

Since the November 2015 meeting of the Committee of Presidents of Medical Colleges the following changes in Directors has occurred:

<table>
<thead>
<tr>
<th>Name</th>
<th>College</th>
<th>Date of Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Michael Hollands</td>
<td>CPMC</td>
<td>cessation 12 November 2015</td>
</tr>
<tr>
<td>Dr Anthony Cross</td>
<td>ACEM</td>
<td>12 November 2015</td>
</tr>
<tr>
<td>Dr Anthony Lawler</td>
<td>ACEM</td>
<td>12 November 2015</td>
</tr>
<tr>
<td>Professor Michael Harrison</td>
<td>RCPA</td>
<td>12 November 2015</td>
</tr>
<tr>
<td>Professor Peter Stewart</td>
<td>RCPA</td>
<td>cessation</td>
</tr>
<tr>
<td>Professor Christopher Milross</td>
<td>RANZCR</td>
<td>cessation</td>
</tr>
<tr>
<td>Professor Gregory Slater</td>
<td>RANZCR</td>
<td>1 January 2016</td>
</tr>
</tbody>
</table>
Item 5.7 Other Governance Matters

At the 12 November 2015 meeting of CPMC the issue of continuity of College Presidents following retirement to function as a voting non-Director on the Committee was raised and the Executive has listed this matter for consideration at this meeting. The request has been made by one Committee member and it is unclear how many others support such a notion. In order to assist the Directors in this matter the secretariat provides the following governance advice.

**CPMC Constitution:** this legal framework clearly sets out the governing rules. With respect to the composition of the Committee and its Executive and power to delegate, the relevant clauses are 5 and 7.

At clause 5.3 the rules in relation to the composition of CPMC state it shall comprise one representative nominated in writing by a Member being a current President or Vice-President or equivalent office holder of the Member.

At clause 7 relating to the Executive, 7.1.1 it shall comprise

- the Chairperson;
- (b) the Chairperson-elect (if any); and
- (c) 4 other Committee members elected to the Executive by Committee members at the first meeting of the Committee after the Annual General Meeting.

At clause 7.1.2 and subject to them continuing to be the duly nominated representative of a Member, each of the 4 Committee members elected pursuant to sub-clause 7.1.1(c) shall hold office on the Executive for the duration of that Committee and shall be eligible to stand for re-election to that office.

Therefore the CPMC Constitution does not provide for continuity of non-Directors on the Committee. Should this be considered a matter for development the Committee would need to agree to undertake a governance review which would need a special sub-committee to be established and resourced to fulfil the objective of completely overhauling the company governance structure because for any one change there usually results in recommendations to revise other clauses, and the process can be time consuming and costly.

**Advice:** Constitutional reviews only take place when the business of the company has to change or there are flaws evident, which prevent proper business being carried out. These reviews are costly and time consuming.

Secretariat notes there has not been to-date any barrier to the Committee undertaking its work due to flaws in the Constitution, and nor has the Committee been unable to function due to inadequate experience available from within the membership. Secretariat also notes that if the Committee were to direct a name change this does not require a governance review but it does need agreement at the AGM and costs to process through the relevant agencies.

A conservative estimate of the cost of undertaking such a review would be $40K not including the voluntary time of Committee members.

**Recommendation**

The Committee notes the above advice.
Item 5.8 Rotating CPMC meetings

The prospect of rotating the meetings through the Colleges, or meeting in Canberra has been raised as an issue for decision at this meeting.

Members will note that Sydney and Melbourne are regularly rotated to because in general Presidents are located in these two jurisdictions.

A Canberra meeting has been convened occasionally. The May 2015 meeting was held at Parliament House and due to their in-house requirements for catering and security the costs were high and this is despite the CPMC Chief Executive undertaking the majority of the escorts to and from the marble foyer. It was considered to be too prohibitive for future meetings.

CPMC Meeting Requirements

- CPMC Morning Forum comprises 50 people – 11 profession observer organisations and 15 Colleges. The location must be able to comfortably seat 50 people at a table. The Chair has asked for the table to be round. It is challenging finding a suitable venue.
- After morning tea the Colleges only session comprises 32 people to be seated at a table.
- College Presidents have agreed to continue to convene for dinner the evening prior – comprises 16 people and they require a private space. Private spaces are generally available via membership clubs and not restaurants.

Budget for meetings: The allocation for meetings has been based on some in-kind support from large Colleges in the form of providing the space. CPMC pays for all other costs and the travel for the Chair. In recent years the cost has risen because private space at restaurants is very difficult to find and costs have risen generally.

Options

1. Continue to rotate around Sydney and Melbourne in large Colleges with the space to provide adequate seating and also possibly on-site support.
2. Move all meetings to one venue for a year, for example RACP while CPMC Chair is from that College and retain the RACS regional office for the dinner.

Recommendation: FOR DECISION
Item 6.1  Indigenous Health subcommittee

Proposal to envelope existing Collaboration Agreements into a Joint Governance Forum

**Background:** CPMC Co-Chairs the joint subcommittee which meets under the auspices of the AIDA-CPMC Collaboration Agreement to facilitate mutually agreed objectives of strengthening cultural competency and awareness of Aboriginal and Torres Strait Islander (ATSI) peoples and health within the medical sector and growing Indigenous medical doctors into specialists.

The second meeting of the subcommittee occurred on 17 September 2015 within the AIDA conference in Adelaide. This meeting included representatives from the Medical Deans, Confederation of Postgraduate Medical Education Councils, TeORA New Zealand and the Department of Health. There was positive feedback from the session on the workshop on ‘growing our fellows’ which many Colleges were able to attend. Discussion occurred in relation to creating better a more efficient governance structure to support the activities currently occurring under the three separate Collaboration Agreements. It was agreed that the proposal should be taken to the November 2015 CPMC meeting, however due to time constraints the matter was not addressed and it was sent out-of-session. Given not all Directors responded there has been no agreement to the proposal and it is lodged again for Directors approval.

**Proposal for a Common Collaboration Forum**

There currently exists three separate Collaboration Agreements between AIDA and the Deans, CPMEC and CPMC all focused on improving Indigenous health outcomes by training more Aboriginal and Torres Strait Islander doctors through to medical specialists. Each has a different governance structure and limited resourcing which has meant that the level of activity has been variable. Establishing a Common Collaboration Forum would enable vertical integration of Aboriginal and Torres Strait Islander issues across the medical education and training spectrum. It would also enable a reinvigoration for all parties to undertake some joint work to improve the pathways of Aboriginal and Torres Strait Islander medical students and doctors and improve health outcomes for Aboriginal and Torres Strait Islander people.

It is proposed the new governance forum be called the **Collaboration Agreement Forum**, to be co-chaired by the President of AIDA and the President of TeORA with secretariat support provided by AIDA. To facilitate the arrangement the President and CEO of the Medical Deans, CMPC, CPMEC, and TeORa along with the AIDA CEO and CEO of the Medical Deans project, the Leaders in Indigenous Medical Education must be invited to participate. It is further proposed that a representative from the Australian Medical Council (AMC) and the Department of Health be invited to participate. The Forum would meet every six months and provide an update against their collaboration agreement and the joint work progressed between meetings, including from the partner perspective. Should the common forum be agreed, there will be a project proposal submitted to the Department of Health to fund the initiative (under their strategy) which would fund secretariat support.

**Recommendation:** That Directors agree to support the new governance structure as outlined.
Item 6.2 National Medical Training Advisory Network FOR DISCUSSION

This paper is FOR DISCUSSION concerning the NMTAN in terms of CPMC participation and contribution.

Next NMTAN meetings scheduled in 2016: 10th March 2016, 21st June, 20th September, 29th November.

NMTAN background: The establishment of the National Medical Training Advisory Network (NMTAN) was approved on 10 August 2012 by the then Standing Council on Health (SCOH) as a mechanism to enable a nationally controlled medical training system in Australia. The NMTAN is managed by the Health Workforce Reform Branch in the Department of Health.

The NMTAN provides guidance to the development of a series of medical training plans to inform government, health and education sectors. In addition, the NMTAN provides policy advice about the planning and coordination of medical training in Australia, in collaboration with other networks involved in the medical training space.

In doing the analysis of supply and demand and determining the capacity for and distribution of vocational training, it will also assist in identifying the capacity of:

- Each college to support training
- Public and private sector to support training
- The health sector to support training in regional and rural areas.

CPMC is represented on the NMTAN by the Chair. Professor David Watters attended the December 2015 meeting on behalf of the Chair. The background to the NMTAN is at Attachment A to this paper.

The Department produced its first Communique after the December 2015 meeting. It outlined the progress on the supply and demand modelling work for medical specialties. The modelling of the anaesthesia workforce is expected to be completed in early 2016 followed by General Practice.

The priority listing for the next round of modelling includes the specialties of obstetrics and gynaecology, radiology (including radiotherapy), emergency medicine, ophthalmology, intensive care and dermatology.

The ‘Changing clinical work with projected changing burden of chronic disease’ project is to await input from the Primary Health Care Advisory Group and thereafter work will continue to be aligned with other relevant initiatives including the planned modelling of the GP workforce. There are links with the STP review.

The recommendations arising from the Medical Intern review is being managed under the HWPC and the next phase will focus on the feasibility, prioritisation and sequencing of them.

NMTAN is going to be start to collaborate with the National Nursing and Midwifery Education Advisory Network which is expected to commence in 2016.
The next meeting of NMTAN is scheduled for 10 March, 2016.

Professor David Watters may wish to update members on the meeting and open it up for general discussion in the context of the strategic planning discussion and challenges for Colleges working towards a balance in supply. His notes are provided at Attachment B.

Guiding Questions include:

1. Role of NMTAN in overarching national strategic plan for Australia’s future health workforce – what is government planning to do with workforce and is the work of NMTAN useful?
2. What decisions have been made at the meetings?
3. What decisions have been made out of session?
4. What decisions have been made in relation to medical training outside the NMTAN process? (Curtin Medical School is an example)
5. If NMTAN didn’t exist there would still be data modelling capability in the Department to produce workforce analyses based on data provided by the Colleges and other entities.
6. How confident is CPMC of the analyses produced and does the process support and enhance College training programs?

Recommendation: Directors to note the above information and discuss NMTAN.
Attachment A: Background to the NMTAN

The NMTAN was established in response to the *Health Workforce 2025: Doctors, Nurses and Midwives* report. The report found there were insufficient general practitioners and specialists in regional and rural Australia, some medical specialties were oversubscribed, and there were fewer generalists as a result of increasing specialisation and sub-specialisation of the medical workforce.

The NMTAN Executive Committee is made up of member organisations with an interest in medical training, including medical colleges, universities, local health districts, state and territory health departments, employers, regulation and accreditation agencies, prevocational medical education agencies, trainee doctors, consumers and the Department of Health. The members bring with them a wide range of experience in the issues of medical education and training.

Function

The main function of the NMTAN is to provide policy advice on medical workforce planning and produce medical training plans to inform government, health and education sectors. In addition, the NMTAN will develop policy advice about the planning and coordination of medical training in Australia, in collaboration with other networks involved in the medical training space. The committee is also responsible for producing an annual report of medical education and training, including undergraduate, postgraduate and vocational training projections.

These functions will be carried out according to five key principles:

1. Training of the medical workforce should be matched to the community’s requirements for health services, including where those services are required geographically and in what specialty.
2. Matching supply and demand for medical training should recognise the changing dynamics of the healthcare system over time, including advances in service models and workforce development trends.
3. Medical training should be provided in the most effective and efficient way that preserves the high quality and safety of Australia’s current training system and the sustainability of the health service delivery system.
4. Training requirements should be informed by relevant and up-to-date information about future service needs.
5. Training places for Australian trained medical graduates should be prioritised over immigration of overseas trained doctors to fill workforce gaps in responding to short- and long-term workforce need.

Attachment B: Notes taken by Professor Watters from the 1 December 2015 meeting

1 The Minutes of the last meeting were approved (17th September)

2.1 Presentation on Anaesthetic Workforce - Maureen McCarty

Since the presentation in Canberra CPMC meeting, ANZCA have been extensively consulted, and A/Prof David Scott was invited for this part of the meeting.

- 2014 Figures: 4482 registered, 4135 employed, 4021 clinicians, 37 in Admin, 19 Teacher/Educators, 19 Researchers, 5 others (NHWDS, Medical Practitioners, 2014).
- Q&A: These numbers do not include GP anaesthetists.
- Av age 49, Females 27.1%, 42.5 hours per week, 72 % under 55, av 43.7 hrs per wk
- This is a younger workforce than other specialties. More Joint specialists (e.g. anaesthesia and ICU) included.
- Labour Force Survey: Hrs worked by gender and clinical + total hours - 5 hours decrease is down to 38 hours on average.
- Trainees - Sources: 1069 (ANZCA) v 1098 (NHWDS) - thus similar in numbers
- 45.2% female trainees,
- Presented maps of geographic distribution, 97% trainees in public sector
- 421 prevoc drs intending to undertake Anaesthetic training: 42% of those considering anaesthetic training (provoke intention) of intends are female. 63% of whom were based in NSW or Victoria.
  (197/433 got into training program in 2013)

Demand: based on MBS data and acute inpatient hospital data

- DRG’s - 10 that include an anaesthetic service during a hospital stay.
- Forecasting models based on utilisation data - to 2030
- Demand rate is 3.1% per annum
- [Mathematical modeling used ‘smoothing methods’ to cope with sharp changes/spurious peaks due to government incentives [eg bowel screening funded till 2019 so relevant to colonoscopy anaesthesia].

Training Pipeline Forecasts suggests about 10% attrition rate and there will be 250 odd new trainees in 2030 to produce 230 odd anaesthesia graduates, though this included 160IMG’s of which about 40 are substantially comparable.

NOTE they are continuing to assume there will be an importation of IMG’s to provide part of Specialist workforce. They are working with the Immigration Department and the CPMC letter to Immigration re IMG’s is at risk of having no effect because NMTAN are supporting ongoing immigration of doctors. John Horvarth is strongly suggesting HW (Vol3) 2025 projects a shortage- do we agree with this interpretation. I and others presented advocated that we do not need to import IMG’s as specialists.
Committee of Presidents of Medical Colleges

Projections: current clinical hours = 38 hours.

- Modelling system is based on hours - Made up of Total Hours, Clinical hours 38, Specialist hours 35.
- Stakeholder feedback seems to suggest there is an underutilisation of anaesthetists which correlates with their hours. No data on what proportion of stakeholders might want to work more [in discussion only about 10%].
- The risk of inaccurate projections is thus increased and the group emphasized this in discussion. AMA (Stephen Parnis) supported this view. David Scott suggested an ANZCA survey showed only 12% of anaesthetists wanted to work more hours.

2.2 Priorities for Next Workforce Reviews:

- Obstetrics & Gynaecology and GP’s
- Stephen Parnis (AMA) - supports O&G which has distribution problems but also radiology (Medical Imaging) and pathology
- Emergency Medicine – noted to have highest number of trainees to consultants.
- Dermatology - STP funds a quarter of training positions in Dermatology
- Generalist specialties - General Medicine and General Surgery – decision or advice that this was not a pressing priority and would be challenging so leave out of list to do at present.
- Richard Doherty discussed term “top level” scope of practice and “lower level” scope of practice and possible need for balance between them.
- DW mentioned RACS “generalism and extended scope of practice” principles but also RACS definitions of narrow scope, broad scope, extended scope of practice with principles for how to work in an extended scope of practice situation.
- Discussion of the term "Career Medical Officer" - rejected in favour of "Medical Officer". There will be increasing numbers of doctors in the future who don’t choose to train in a specialty or who can’t get into specialty training. These do not deserve to be called “Career Medical Officers” as if they have done specialist training or that their experience across a broad field makes them the hospital equivalent of a Specialist GP or Fellow of ACRRM.

3. Review of STP Program of critical importance for 2017 allocations and planning for members of CPMC

- The Commonwealth Department has received over 30 submissions in response to the discussion paper, including submissions from all colleges involved in the STP, most state and territory governments, and a number of stakeholder representative bodies. The Department is meeting with colleges from mid-November to early December 2015 to discuss their submissions. Time will be tight.
- KPMG has been engaged by the Department to assist in developing a potential methodology for the allocation of training posts from 2017. It is expected that this phase of the review will be completed by early January 2016.
- The Department is proposing further consultation with colleges and NMTAN in late January 2016 to further inform the development of recommendations.
It is unlikely that the timetable for NMTAN meetings will align with the need to finalise consultations on potential allocation methodologies for STP training posts.

It is suggested that NMTAN consider alternative consultative arrangements, such as out of session papers or a small sub group, to facilitate this process.

As reforms are expected to be implemented in 2017, determining alternative consultative arrangements will facilitate early advice to the colleges, jurisdictions and training settings about the any changes.

NB Discussion papers with a list of targeted questions and development of the methodology. January 16 - stakeholders are likely to be consulted. The Colleges are being consulted by Kate McCaulay. Plan to incorporate stakeholder feedback. I am not sure what advice we have already provided.

I have volunteered CPMC to be a member. I believe this was accepted. Angela should write to NMTAN to confirm willingness to be involved.

Decision: A Subcommittee of NMTAN will be delegated to provide advice to the government. This will include doctor in training, CPMC, AMA, Private Health Sector, and two others.

4 Review of Medical Intern Training

- The final report of the Review of Medical Intern Training, including the recommendations, was provided to Health Ministers for consideration and noting at the COAG Health Council (CHC) meeting held 6 November 2015.

- Richard Doherty declared a conflict of interest as a member of the review panel.

- The outcome of Phase Two will be provided to the CHC in the first half of 2016, which will enable it to consider its formal response to the report recommendations.

- The final report is available on the COAG Health Council website http://www.coaghealthcouncil.gov.au

The Review - addressing each Term of Reference: Overview of findings

1. The purpose of internship and whether the current model remains valid and fit for purpose: While the concept of a general internship remains valid, in light of major changes in the health system and in medical education, the weaknesses of the current internship model significantly undermine its longer term fitness for purpose.

2. Effectiveness of the intern year in producing doctors with appropriate skills and competencies to meet national health care needs including generalist practice: The internship is currently not aligned with societal health care needs, plays a limited role in supporting generalist practice and has variability in the quality of the learning experience.
3. The role of internship in supporting career decision-making by doctors: While the internship has a role in career planning, a more holistic approach to planning is needed than the current reliance on clinical exposure.

4. Models to support expansion of intern training settings: There is a need for expansion in intern training settings for educational and capacity reasons and to align the internship with modern health care delivery.

There are 7 specific Recommendations (Appendix to this report) -

The advice to ministers as to which recommendations to accept is still being considered but what is being considered is not being shared. I asked [Maureen] for specific questions to which CPMC could provide specific answers.

5 UPDATE ON THE NATIONAL STRATEGIC FRAMEWORK FOR CHRONIC CONDITIONS

Workforce issues regularly raised during the consultations included:

- The need for an appropriately skilled workforce; a generalist workforce, rather than specialised, and a diverse workforce that represents a broader demographic.
- The impact of funding models on workforce distribution/mal-distribution and further exploration into providing incentives for GP’s and allied health in managing chronic conditions.
- Supporting health workers and professionals to work to their full scope of practice – MBS changes were identified.
- The need to continue to build workforce capacity through tertiary education, training and professional development, with a focus on:
  - working effectively in inter-disciplinary teams;
  - integration across health sectors;
  - providing effective prevention, self-management education and care coordination in both primary and secondary settings; and
  - understanding patient-centred care, health promotion and a whole of-life approach.
- Supporting the health workforce with tools and systems such as detection tools, recall/notification systems, decision support tools, evidence-based clinical pathways, models of care and telehealth options.
- Understanding the impact of the implementation of My Health Record in facilitating coordinated care and information sharing between health workers and with the individual.
- A public on-line consultation process will be held in early 2016 to invite further comment on a revised draft Framework. NMTAN members will be notified when the online consultations process commences.

It is expected that the Framework will be considered by the Australian Health Ministers’ Advisory Council and released in late 2016.
6 Better Evaluation for Care of Health (BEACH) – Richard Doherty

- The report on the Better Evaluation and Care of Health (BEACH) program and the Medicare Benefits Schedule (MBS) were developed as agreed at the 22 September 2015 NMTAN meeting, and discussed at the recent subcommittee meeting (see Attachments 1 and 2).

- The data from the BEACH study and the uptake of MBS items show a large increase in service delivery for chronic disease management in general practice between 2010 and 2015. The data provide information on the quantity of service delivery, but not on the model of delivery or the quality of the services provided; nor can the data be used to determine the proportion of time allocated to chronic disease management by the various professions. Specific models of care need to be identified to enable modelling of the workforce demand. As suitable chronic disease models of care are currently being determined through the work of the Primary Health Care Advisory Group (PHCAG), it seems practical to await the results of this work.

The below information is based only on publically available BEACH data and provides limited information on the medical specialists and allied health service groups to whom GPs refer patients with chronic conditions.

In 2013-14:

- Chronic problems accounted more than one-third (36%) of all problems managed in general practice.

- At least one chronic problem was managed at 42% of encounters, and the most frequently managed chronic problems at an average rate of 56 per 100 encounters.

- 30 chronic problems accounted for 80% of all chronic problems managed.

- Half of all chronic problems managed (51%) were accounted for by the top seven chronic problems: non-gestational hypertension (15%), depressive disorder (8%), non-gestational diabetes (7%), chronic arthritis (7%), lipid disorder (6%), oesophageal disease (5%) and asthma (4%).

- Extrapolation of these results suggests that, across Australia in 2013–14, there were 11.5 million encounters involving non-gestational hypertension, 5.7 million involving depression and 5.6 million involving non-gestational diabetes.

Changes over the decade 2004-05 to 2013-14:

- There was a significant increase over the decade in the management of chronic conditions (from 52 to 56 per 100 encounters).

- About 1.4% of encounters were claimable as chronic disease management items.
• There was an increase in the average number of problems managed at encounter, from 146 per 100 encounters in 2004–05 to 158 in 2013–14. This change was reflected in an increase in the number of new and chronic problems managed per 100 encounters.

• Of the encounters claimable from Medicare/DVA, the proportion claimable as chronic disease management items increased significantly.

• The increase in prescription rate associated with patient age is probably a reflection of the problems under management, as the rate of chronic problem management increases with patient age.

• There were significant increases in the rate at which practice nurses and Aboriginal health workers were involved in management of check-ups, atrial fibrillation/flutter, diabetes, vitamin/nutritional deficiency, and hypertension. Many of these increases may have been stimulated by the introduction of MBS item 10997 for services provided to a person with a chronic disease, in 2007–08.

• There was a significant decrease in the proportion of encounters with patients who were new to the practice (from 9.1% in 2004–05 to 6.6% in 2013–14). This may be due to the need for continuity of care for chronic conditions.

• National Strategic Framework for Chronic Conditions

• Workforce issues regularly raised during the consultations included:

• The need for an appropriately skilled workforce; a generalist workforce, rather than specialised, and a diverse workforce that represents a broader demographic.

• The impact of funding models on workforce distribution/mal-distribution and further exploration into providing incentives for GP’s and allied health in managing chronic conditions.

• Supporting health workers and professionals to work to their full scope of practice – MBS changes were identified.

• The need to continue to build workforce capacity through tertiary education, training and professional development, with a focus on:

  o - working effectively in inter-disciplinary teams;

  o - integration across health sectors;

  o - providing effective prevention, self-management education and care coordination in both primary and secondary settings; and

  o - understanding patient-centred care, health promotion and a whole of-life approach.
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

• Supporting the health workforce with tools and systems such as detection tools, recall/notification systems, decision support tools, evidence-based clinical pathways, models of care and telehealth options.

• Understanding the impact of the implementation of My Health Record in facilitating coordinated care and information sharing between health workers and with the individual.

• A public on-line consultation process will be held in early 2016 to invite further comment on a revised draft Framework. NMTAN members will be notified when the online consultations process commences.

• It is expected that the Framework will be considered by the Australian Health Ministers’ Advisory Council and released in late 2016.

Appendix -The 7 Recommendations on Internship

RECOMMENDATION 1: That the internship be changed to: Provide clinical experience in the full patient journey and exposure to a variety of patient care settings, with at least some time outside of a single care setting. Require demonstration of specific capabilities and performance, within a time-based model. Ensure robust assessment of capabilities and feedback on performance. Ensure doctors in training have sufficient responsibility, under supervision, to develop competence and confidence while maintaining patient safety. Enable and require a philosophy of individual accountability for learning.

RECOMMENDATION 2: That the internship should have entry requirements that reflect agreed and defined expectations of work-readiness that graduates must meet before commencing. Specification of the expectations and certification of work-readiness should be undertaken collaboratively by employers, universities and the Australian Medical Council within 1-2 years.

RECOMMENDATION 3: That the current model of internship move to an integrated, two-year transition to practice model, with the first postgraduate year continuing as a prerequisite for general registration and with a certificate of completion, auspiced by the Australian Medical Council, to confirm a set of agreed outcomes aligned to vocational training. This should occur within 2-5 years. We recommend a model based on the first two postgraduate years and which maintains the current flexibility to enter into vocational training from the second postgraduate year. We also recommend testing the option of the two-year period being the final year of university and first postgraduate year.

RECOMMENDATION 4: That the following occur to support the change process and further investigate aspects of the models:

a. Revision of the intern registration standard to emphasise capabilities and performance and experience in the full patient journey and de-emphasise time-based elements – to be undertaken by the Medical Board of Australia in close consultation with jurisdictions, employers and others, within 1-2 years.

b. Development of a detailed and measurable two-year capability and performance framework, that builds on existing curriculum frameworks - to be undertaken through a national process involving jurisdictions, the Australian Medical Council, employers, colleges, postgraduate medical councils, universities and others, within 1-2 years.

c. Development of a certification process for the two-year transition to practice model, to be undertaken by the Australian Medical Council in conjunction with postgraduate medical councils, jurisdictions and others, within 1-2 years.

d. Evaluation of different models of capability assessment, including resource requirements – to be undertaken across a number of jurisdictions and patient care settings within 2-5 years.
e. Evaluation of options for an e-portfolio to provide greater individual accountability for learning and support the assessment process – to be undertaken within 2-5 years.
f. Identification of accreditation arrangements for a two-year transition to practice model – to be undertaken by the Australian Medical Council in collaboration with jurisdictions, universities, postgraduate medical councils and others, within 2-5 years.
g. Examination of the capacity to assess and certify the capabilities and performance required for general registration within university programs – to be undertaken across different medical programs and health service settings within 2-5 years.

RECOMMENDATION 5: That career planning across the medical education continuum is better aligned with societal health and medical workforce needs. Specifically, that:
   a. Universities provide targeted career information to medical students, within 1-2 years.
   b. Colleges make available information on entry requirements and success rates for selection into vocational training programs, within 1-2 years.
   c. Employers provide formal, structured career planning during the transition to practice period, including assisted self-appraisal and self-reflection, within 2-5 years.
   d. Jurisdictions provide best available data on projected workforce demand at regular intervals, such as every 3-5 years, within 2-5 years.

RECOMMENDATION 6: That expansion of training settings is further supported through:
   a. Jurisdictions and the private and not for profit sector identifying and, where feasible and affordable, implementing opportunities to expand suitable placements in private, not for profit and community settings, within 1-2 years.
   b. The Commonwealth Government providing targeted access to Medicare billing arrangements for PGY2 doctors placed in general practice settings, within 1-2 years.
   c. Analysis of interns’ service contribution in different settings to inform discussion on their role and help define benchmarks for private sector contribution to their training, within 1-2 years.

RECOMMENDATION 7: That the following research and development activities occur to support the change process:
   a. Identification of requirements for, and possible approaches to a national training survey to capture ongoing performance data, within 1-2 years.
   b. Identification of other relevant data indicators, and implementation of these, to support ongoing monitoring and evaluation of the change process, within 1-2 years.
   c. Provision of dedicated, time-limited support for local innovation initiatives that have the potential to create sustainable improvements in the training experience, within 2-5 years.

END REPORT
6.3 Business plan reporting + round up from strategic planning forum

This paper has been prepared in advance to complement any discussion at the forum as well as any follow-up at the CPMC meeting. The regular reporting against the CPMC business plan is included.

- Since 2010 CPMC has had in place a formal strategic plan. The strategy was initially internally focussed and has subsequently shifted to more external engagement.
- CPMC has always been responsive on important matters [http://cpmc.edu.au/about-us/policy-statements](http://cpmc.edu.au/about-us/policy-statements) reflects the core business of CPMC in so far as the issues of workforce (generalism and distribution) along with the role of a medical specialist are key to the mission of all Colleges; along with prescribing and the health of all Australians with the statement on tobacco.
- CPMC releases a *Communique* after each quarterly meeting which is widely distributed and on the website (hence public). Media statements are developed on contemporary broader sectoral issues such as BDSH, healthcare variation, education tax.
- CPMC has also issued monthly general newsletters, which reflect information for members in between the quarterly meetings. These can be found at: [www.cpmc.edu.au](http://www.cpmc.edu.au) front page. CPMC also utilises the @CPMC_Aust twitter site to respond swiftly to general sectoral policy issues and commentary. The Chair also responds to tactical media arranged by the CEO.

In December 2015 the CPMC Executive agreed on an additional list of policy issues to be developed up for inclusion in the 4th February 2016 range of meetings with politicians and senior officials. The CEO developed background papers on the following issues:

- Health Care Reform
- The MBS review
- Australia’s health workforce including STP and regulation
- End of Life Care including an advanced care directive campaign
- Medicinal cannabis and current status.
- Private health insurance review and reforms affecting access to bulk billing incentives for pathology, access to PHI coverage for avoidable events and possible removal of incentives for coverage.
- Medical research expanding clinician led research opportunities

In February 2016 there is consideration being given to establishing a national obesity campaign joining up with like-minded organisations and the AAHMS and NHMRC in a similar way to what has happened in the UK. So members may wish to consider whether CPMC should include in its strategic policy development over the next two to three years, developing campaign statements to align with those occurring in like-minded health care systems (UK, Canada, NZ).

In moving forward members may wish to focus future policy development activity on:

- The sustainability of Australia’s health care system: such a paper would build upon the literature already available and make statements on system reform, primary care, workforce, financing and reforms to the MBS, PBS and private health.
- Obesity: such a paper would review existing College statements on this social health matter and work to establish a campaign enabling greater engagement with existing academic institutions (AAHMS and NHMRC) as well as linking into structures such as the Charles Perkins Centre at USyd.

CPMC meeting 18th February 2016 at RCPA
These two issues could fit with the usual advocacy, policy and government relations exercises as well as add value in areas where we know there are gaps in knowledge and CPMC could provide the expert advice it does well.

The CPMC Chair would also like the issue of ‘sign off’ on policy determined for example all Presidents, 50%.

Members should note that attached is the February 2016 report against the business plan, which shows that CPMC is meeting the performance measures.

**Recommendation:** Note forum decisions and agree on level of agreement in sign-off policy.
In 2015-17 CPMC will work towards achieving the Strategic Goals Towards 2017 according to the following objectives and actions. This plan builds upon the 2011-13 CPM Strategic Plan, and in particular that CPMC was a forum for dissemination of information and exchange of ideas among presidents and colleges, and between colleges and jurisdictional representatives.

### Objective 1: CPMC will provide a Morning Forum for discussion with the membership on issues and with external organisations who wish to liaise with the Colleges.

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<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
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<tr>
<td>1.1 Maintain standing invitation to key health sector leaders and organisations to participate at CPMC meetings</td>
<td>Invitees will include: Secretary Department of Health Representatives of: • Australian Medical Council • National Health &amp; Medical Research Council • Medical Board of Australia • Australian Indigenous Doctors’ Association • Australian Commission on Safety &amp; Quality in Healthcare • Australian Medical Association • Medical Deans of Australia and New Zealand An may include: • Other representatives • Private Health organisations • Public Health organisations</td>
<td>In Feb16 added the AAHMS To consider adding Private Health Care Australia CEO address</td>
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<td>1.2 CPMC will organise forums on sector issues of interest to members and intercollege discussions</td>
<td>Forums and discussion sessions organised as required (up to 2 per yr) Possible topics include: • Workforce issues and innovative models of care. • Regulatory policy and accreditation including Medicare and PBS</td>
<td>• In Feb16 added workforce • NPS • Academy • Address from the AMA.</td>
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<td>1.3 Opportunity for members to share information and network with ‘Profession Observers’</td>
<td>Sufficient time for members to raise topics, develop papers and ask questions to be scheduled for each meeting.</td>
<td>In Feb 16 added lead College President to items</td>
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**Objective 2:** CPMC will consolidate its influence by meeting with sector and political leaders and through representation at other meetings.

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<th>Actions</th>
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| 2.1 Advocate on CPMC issues to political leaders | • Minister for Health to attend one CPMC meeting per annum  
• Chair & CEO to attend Ministerial Roundtable events  
• Chair / Executive to meet with Ministers once every quarter as part of a government relations day with meetings to be including:  
  • Minister Health  
  • Opposition Health spokesperson  
  • Education Minister  
  • Opposition Education/VET  
  • Foreign Minister  
  • Others as required | In Feb 16 invited Minister to June meeting  
In Feb 16 have met with Minister for Health, Opposition and Secretary.  
Plan to meet with Senator Nash re rural health and related issues |
| 2.2 Develop and maintain strong relationships with key sector agencies in medicine, and develop new contacts | • Participate in the regular Secretary’s meetings  
• Conducts a strategic planning forum with key senior officials to steer workforce and other medicine issues  
• Departments of Health in the areas of strategic policy, workforce, rural and population health  
• Colleges CEOS forum & communications | In Feb 16  
• Have done 3 breakfasts  
• 17 Feb strategic planning forum  
• Attend all CEOs forum  
• Initiated the communications process |
| 2.3 Chair or delegate to attend key health sector meetings including  
  • NMTANs  
  • DHS Stakeholder Reference Group  
  • Medicare  
  • Safety and Quality Forums | • Attend all meetings as required and report to the quarterly CPMC meetings. | In Feb 16  
• NMTAN attended  
• DHS SRG  
• S&Q Forum abolished |
Objective 3: CPMC will respond to sector issues and members’ requests according to CPMC’s goals and resources.

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<tr>
<td>3.1 CPMC Secretariat to build support from sector College</td>
<td>• CPMC has access to member Colleges for support to cover event logistics and coordination similar to CMC, NZ.</td>
<td>In Feb 16 part of strategic planning forum to determine support</td>
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</table>
| 3.2 Responds proactively to issues | • CPMC conducts annual planning forum which determines principles of response to enable policy development  
• Responds within 7 days to internal requests and 10 days to external requests  
• CPMC develops quality submissions on issues of commonality delivered in a timely manner  
• CPMC participates in coordination of submissions on issues of commonality but where lead may be from member  
• Information provided to stakeholders via the communique after each quarterly meeting.  
• Twitter monitoring to enable topics of interest to be sent to members | All of these done                                                                                           |
| 3.3 Advocate for College issues within the sector | • Newsletters  
• College publications  
• CPMC website (load up some data)                                                                                                                                                                | Added newsletter in July 2015, monthly                                                          |
| 3.4 Establish inter-collegiate knowledge through dialogue at CPMC meetings or in separate forums | • Maintenance of strategic issues session at CPMC meetings for Members  
• Establish the specialist trainee inter-collegiate forum  
• Maintain the CPMC strategic liaison lunch                                                                                                                                                     | Need to decide on the specialist trainee inter-collegiate forum  
A post Fed Budget strategic luncheon TBC                                                              |
| 3.5 Research and forward projects | • Complete the Indigenous cultural competency curriculum project  
• Compete for special project work to build capabilities                                                                                                                                         | Completed                                                                                       |
Item 6.4 Fee Review – new model and fee capping 2016-17

Background: Members will be aware that an economic modelling exercise occurred by the CEO, CPMC in early 2015 to arrive at a series of options for realising greater equity in the spread of subscription fees, including moving to a four level fee structure based on College size, but that process did not result in any agreed outcome due in part to timing.

A fees working group was established after the August Directors meeting and chaired by RCPA CEO Dr Debra Graves and comprising Ms Linda Smith (RACP CEO) and Mr Phil Hart (CICM CEO) supported by CEO CPMC. The working group met via teleconference and discussed maintaining the existing subscription fee model; introducing a base fee of $8000 and then $1.50 head count rounding the fees; or capping. Revising the current formula to increase the base fee to $8000 with $6 for each of the first 2000 Fellows with $1 for each Fellow above 2000 was deemed to be the best approach if moving toward a more equitable model, and then a process of rounding out occurred to spread the fees. Each College CEO was consulted individually on the revised model. There was general agreement by the Colleges that this approach would be satisfactory.

Current Status: The model was presented to the November 2015 meeting recommending the rounded option to apply from 2016-17. As a result of discussion the Chair indicated this matter would return to the February 2016 meeting to address some of the concerns raised and to resolve the matter.

Concerns raised and responses

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<th>Concern</th>
<th>Response</th>
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<tr>
<td>1. Why CPMC is attempting to make surpluses?</td>
<td>CPMC was just solvent in 2013 and has to make provision for risk both known and unknown. In that regard the example RACS having incurred a large cost for the Expert Advisory Group on Bullying and Harassment means CPMC requires a buffer in case of a potential large legal bill. The intention is to maintain a small surplus of approximately half annual operational costs.</td>
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<tr>
<td>2. What is considered to be a normal buffer?</td>
<td>CPMC maintains the aim of holding $130-150K in reserves which represents 12 months operational capacity</td>
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<td>- Is it the ability to pay staff and operational costs without any injection of fees for 12 months?</td>
<td></td>
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<td>- Is it 2 years?</td>
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<tr>
<td>3. Potential for Colleges to contribute on top of annual fees on a case by case basis</td>
<td>This may be a viable option should CPMC Directors determine it appropriate for a large project to be undertaken with adequate resourcing over a 12 month period.</td>
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<tr>
<td>4. Returning surplus to College members if CPMC is dissolved</td>
<td>CPMC is structured via its Constitution. CPMC would not return surpluses but rather manage the wind-down to ensure administrative arrangements and legal fees were payable as well as staffing processes.</td>
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<tr>
<td>5. Why has there been a CPI increase?</td>
<td>CPMC pays CPI increases as do Colleges.</td>
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Ms Linda Smith (RACP) noted that a number of College CEOs had discussed member subscription. RACGP was concerned it is paying the largest amount, and would like a cap on the total fees. The new model would undoubtedly result in small rises for Colleges with growth in the number of Fellows but only marginally. It is reasonable to consider a capping of fees payable for the largest College member. Therefore, if a cap on the fees payable were to be considered then a simple resolution would be to cap whatever the 2016-17 fees calculated to be and maintaining that for the RACGP for 3 years and reviewing it thereafter.

The main issue for the CPMC Directors is ensuring the total fees generated covered the cost of operations, while also allowing for reserves to be generated. This model will do so and with some consideration of alternative sources of income such as sponsorships or project funding the new approach will ensure CPMC remains viable.

**Recommendations:**

That Directors

1. Note the above overview and response to concerns raised at the November 2015 meeting;
2. Agree on the model as developed to apply for the 2016-17 financial year, and
3. Agree on capping the amount payable by the RACGP at whatever the 2016-17 revised model is calculated at for a period of three years.
Item 6.5 Rural Health Continuing Education & Next Steps

This item is a regular piece on the CPMC agenda aimed at updating members on the progress of the RHCE project and then moving forward to any new support for rural and regional specialists in Australia.

Current RHCE program

Projects - In 2015, all 13 eligible Colleges led, collaborated or participated in at least one of the 14 RHCE projects. $1 million in project grants delivered a very successful year for RHCE, including: 22 clinical practice reviews, 13 workshops, 11 webinars, 5 eLearning modules, an App for clinical audit, and an online platform. Details are available at http://ruralspecialist.org.au/current-projects-3/  

All projects have now been completed, and most contracts governing them have been acquitted. It is anticipated this will be completed before the end of February. Modules and links to eLearning content for six projects have already been added to the RHCE website (see http://ruralspecialist.org.au/news/). More content will be uploaded in the coming weeks.

Individual Grants - RHCE offers grants of up to $10,000 to rurally-based specialists to attend Continuing Professional Development (CPD) and upskilling courses. Of the 50 successful grantees in 2015, 47 completed their courses and 3 withdrew.

Since the commencement of the RHCE program in 2010, 120 rural medical specialists have completed a RHCE-funded grant activity. Of the 118 who completed an evaluation:

- 97% either strongly agreed (72%) or agreed (25%) that the participation in the CPD event helped them meet their learning objectives identified in their grant application.
- 93% of respondents agreed that the participation in the CPD activity has helped maintain their practice standards.
- 61% would not have participated in the CPD activity without RHCE funding.
- 100% found the RHCE support staff to be either very supportive or supportive.

Winding up of existing RHCE - A meeting occurred between the CEO, CPMC (also National Director RHCE) and Program Manager RHCE with the Department of Health concerning the transitioning issues for RHCE given the funding agreement had expired on 30 June, 2015. The Department advised that the previously proposed transition of the RHCE Program to Primary Health Networks would no longer occur. Members will recall this was an obligation in Variation 4.

RHCE has expired with projects and grants currently being acquitted and reporting processes occurring including administrative issues via the PMU.

Proposal for new funding support – The Department requested CPMC to prepare a proposal to deliver a program to provide professional development support for rural medical specialists. During the period 26 November to 10 December 2015, CPMC sought input from the RHCE Program Management Committee, RHCE Liaison Officers and Continuing Professional Development leads across the 13 non-GP Specialist Medical Colleges.
The overwhelming response from Colleges was to deliver RHCE in the same or expanded fashion, but across a three-year timeframe. The CPMC submitted a proposal which reflected this. However, on 17 December, the Department advised it was not in a position to accept the proposal citing the STP review as one reason. As a result, CPMC prepared a revised proposal which included the following changes:

- Change of name from RHCE to Support for Rural Specialists in Australia (SRSA);
- Three year funding period (1 March 2016 – 28 February 2019);
- Reduced Annual Budget from $1.75M to $800,000;
- No project grant funding stream;
- Expanded grants for individual medical specialists to allow approximate 100 grantees / year (up from 50);
- The program to link to a defined funding stream within a revised Specialist Training Program, focussing on improving supervision skills, cultural competency skills, learning about revalidation, improving practitioner mental health, and addressing bullying and harassment.
- Increased support for the website (www.ruralspecialist.org.au) to allow for rebranding and regular review/update of clinical eLearning content.

CPMC lodged the approved proposal and received advice from the Department that it had accepted it and would seek the Minister’s approval in late December, 2015. CPMC chased status in early January with no response. On 1 February, the Department advised that the proposal would reach the Minister’s office in the week commencing 8 February 2016.

**Current and Future Staffing** - The Department agreed to expand the contract period of the RHCE Program Management Unit (PMU) until 31 March 2016 to allow for a decision on the new program. RACP agreed to continue to house the PMU, and both staff members have been retained for this time.

**Next Steps** - if the revised proposal is acceptable to the Minister, it can be anticipated that CPMC will manage the funds and oversee a new funding agreement commencing 1 March, 2016. The RACP has indicated it will continue to support the PMU. CEO, CPMC envisages no major upheavals during a transition to a new arrangement.

**Governance arrangements** - CPMC will be required to convene a governance structure to manage the program. It is an ideal opportunity for CPMC to discuss appointing a lead College President who can chair a CPMC sub-committee on rural health and the SRSA program.

**Recommendation:** That Directors:

1. note the above update;
2. discuss in general, support for rural specialists in Australia, and
3. appoint a lead College President to support a sub-committee on Rural Health.
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

Item 6.6 Senate Inquiry into the medical complaints process in Australia.

Directors to note that a reference was sent to the Senate Community Affairs References Committee by Senators Xenophon and Madigan on 2 February 2016 on the matter of inquiring into the medical complaints process in Australia. FOR DISCUSSION

Background to Senate Enquiries

The Senate delegates a range of tasks to its committees, and they provide an opportunity for organisations and individuals to participate in policy-making and to have their views placed on the public record and contribute to the decision-making. There are legislative committees which are dealing with bills referred to the Senate, and an Estimates process to oversee performance of departments, including their annual reports, and a References Committee which deals with all other matters referred by the Senate. The Community Affairs References Committee (SCARC) is the portfolio which deals with Health, Social Services and Human Services. The SCARC is chaired by Senator Rachel Siewert, Australian Greens, WA and Deputy is Senator Zed Seselja, Liberal Party ACT.

Background: Independent Senator John Madigan has previously accused AHPRA of not having the capability to manage phone and web data given their past intercepts of doctors under investigation (psychiatrists and doctors treating Lyme disease). The new data retention laws require the Attorney-General to decide whether agencies can be granted warrantless access to telecommunications data.

Senator Xenophon has called for a sweeping enquiry into the medical complaints process in Australia. He has been an outspoken critic of the medical complaints process for AHPRA and has said there are many legitimate questions about fairness and transparency of the current process.

The Enquiry’s terms of reference are:

a) the prevalence of bullying and harassment in Australia’s medical profession;
b) any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;
c) the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;
d) the operation of the Health Practitioners Regulation National Law Act 2009 (the National Law), particularly as it relates to the complaints handling process;
e) whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;
f) the benefits of ‘benchmarking’ complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;
g) the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith; and
h) any related matters.

The submissions due date has not yet been set. The reporting date is 23 June 2016.

CPMC meeting 18th February 2016 at RCPA
Discussion


CPMC has not had a debate about the adequacy of AHPRA investigations. However there has been some opinion given to the role of an independent ombudsman

In 2015 the Telecommunications (Intercept and Access) Amendment (Data Retention) Act 2015 became law and as a result over 60 agencies lost their right to access phone and web data and to do so without a warrant is illegal. There are over 83 agencies which have subsequently made application to the Attorney-General. The Attorney-General is yet to decide whether AHPRA will be allowed to retain its power to access phone and web metadata when investigating doctors. According to their annual report it did so on 20 occasions in 2014-15 for investigation purposes.

Several member colleges have undertaken an assessment of the prevalence of bullying within the confines of using a survey tool developed by RACS.

A submission from CPMC which coordinates input from all member Colleges is recommended. It should reflect statements against each of the terms of reference.

Directors should note the enquiry, discuss it and determine the scope of response.

Recommendation: FOR DISCUSSION
Item 6.7 Private Health Insurance Review

This item has been included in the agenda to update members.

Background

Private health insurance is part of Australia’s mixed model of health care funding and service delivery, offering its members choice and type of services which may not be included under Medicare. There are 35 health funds in Australia and most are not for profit. There are over 48,000 products in the PHI market.

For many people PHI coverage enables access to elective surgery and also avoiding waiting lists. According to the Department of Health 47.4% of Australians covered by PHI as at 30 June, 2015 for basic hospital cover was 11.3 million and for general treatment cover 13.3 million or 55.8% of the population. The PHI Rebate cost the government $5.8B in 2014-15.

The main issue with the PHI industry is sustainability given the factors affecting the broader public system naturally flow onto the private sector. The most commonly raised issues are the increasing ageing of the population and with that chronicity; the cost of the services, and the range available.

Governance arrangements for private health: from 1 July 2015 responsibility for the prudential supervision of private health insurers transferred from the Private Health Insurance Administration Council (PHIAC) to the Australian Prudential Regulation Authority (APRA).

In relation to premiums the government has acknowledged that in recent years the insurers have experienced significant growth in benefit outlays. According to the Department at http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-summary-premiumincreases

- In 2013-14, private health insurers paid more than $16.7 billion in benefits to members, an increase of 9.1% compared with the previous year ($15.6 billion).
- Benefits paid to members are around 86.4% of total premiums paid by members.
- A continued period of benefits growth is forecast.
- Insurers must maintain a minimum level of capital above prudential requirements. This is to ensure they can meet benefit payments to members and operate their business on a continuing basis.
- All insurers have an internal capital target that is well above their minimum prudential capital requirements.
- For-profit insurers usually make dividend payments or capital returns to their shareholders or owners, which reduces the level of their excess capital.

There is no legislation which applies to premium increases. Therefore, each fund makes its case for a rise and it is considered by the Minister and the process is commercial in confidence and not able to be FOI sourced. Each year premiums tend to rise by about 6%. However, for 2016, the Health Minister has demanded the PHI companies provide more information to justify premium increases because she is concerned about the ongoing affordability for consumers. http://www.abc.net.au/news/2016-01-30/private-health-insurance-fee-hikes-must-be-justified-sussan-ley/7126868
Independent Ombudsman: There is a private health insurance Ombudsman which exists to protect the interests of people covered by PHI, found at www.phio.org.au. It deals with complaints as well as managing the website www.privatehealth.gov.au where you can find out about private health insurance and search for and compare selected features for all private health insurance products offered in Australia.

Minister Ley announced a review into PHI on 28 October 2015 with consultations focused on the value of PHI for consumers and long term sustainability for it. The review is aimed at ensuring that consumers can access affordable, quality and timely health services into the future. The scope of consultations will consider ways to:

- Enhance the value of PHI to consumers;
- Encourage increased efficiency of PHI;
- Increase the effectiveness of government incentives for private health, and
- Improve the sustainability.

Links to other reforms: The government has indicated that it will consider potential future roles for PHI within the context of broader changes being considered such as the White Paper on the Reform of the Federation, and the government’s reviews of primary health care and the MBS Review.

Review Consultation Process: on-line consumer input plus officials consulting directly with key industry and consumer representatives. The government released an Issues Paper in November 2015 which clearly outlined the issues for discussion, which are:

- Lack of information and a lot of complexity about PHI products (this links to Informed Choice) raised by consumers
- Exclusionary products or restrictions – some gaps in coverage, excesses payable but if a person chooses to exclude certain items, will that result in greater value for money?
- Effective use of the 3 government incentives (PHI Rebate, Medicare Levy Surcharge, Lifetime Health Cover) and how effective are these in terms of supporting affordability of PHI?
- Value for ATSI, rural and remote consumers when private services are not there.
- It is common for private patients to receive care in public hospitals, and some cover specifically provides just that, but critics argue it does not reduce pressure on a public hospital but it does result an income stream other than from government.
- Prostheses benefit payable by insurers on the Prostheses List and cost drivers.
- Risk equalisation doesn’t provide incentive for insurers to reduce costs.
- Cover for non-admitted hospital procedures – eg chemo, radonc, dialysis would allow for greater equity in access in use of PHI.
- Contracting arrangements and default cover when contracts have not been struck


Discussion: Concerns have been held by hospitals about the use of data from the ACSQHC’s Atlas of Variation in contract negotiations and then refusal by insurers to include avoidable events in coverage. Despite the media coverage concerning the negotiations hospitals signed up to the agreements. Concerns remain by surgeons.

Recommendation: Members to note the update and expectation that PHI reform will feature in the overall May Budget along with MBS reform.
The Review

- Established by Health Minister Sussan Ley in June 2015
- At $20 billion, MBS is the largest single health program – around 30 per cent of Commonwealth health expenditure
- More than 5,700 services funded – many haven’t been re-examined or evaluated since listing.
Why review the MBS?

Feedback supports the need for a review:

- First comprehensive review since inception in 1984

- MBS is a key driver of the way health services are delivered into the community so important supports high-value care over low-value care
  - ‘Low-value care is use of an intervention where evidence suggests it confers no or very little benefit on patients, or risk of harm exceeds likely benefit, or, more broadly, the added costs of the intervention do not provide proportional added benefits. Choosing low-value care consumes resources that could have been expended on alternative forms of care conferring greater levels of benefit, either to the patient in question or to other patients.’

- Some MBS items are structured or used in a manner that does not reflect contemporary and evidence-based practice
  - This includes outmoded services or services that don’t always provide high-value care

- Concerns about complexity and ambiguity in MBS rules and item descriptors leading to confusion among clinicians and consumers

- Health service access gaps or distortions in supply – underuse of high-value items, or the overuse of low-value items
The Taskforce

- Membership is drawn from doctors working in both the public and private sectors with expertise in general practice, surgery, pathology, radiology, public health and medical administration. Consumers are represented.
  - Professor Bruce Robinson, Chair, Dean of the Sydney Medical School
  - Dr Steve Hambleton, Deputy Chair, Representative of PHCAG
  - Dr Matthew Andrews, Clinical Member (Diagnostic imaging)
  - Prof Michael Besser, Clinical Member (Neurosurgery)
  - Dr Michael Coglin, Clinical Member (private provider)
  - A/P Prof Adam Elshaug, Health Technology Assessment
  - Professor Paul Glasziou, Clinical Member (General Practice)
  - Professor Michael Grigg, Clinical Member (Surgery)
  - Dr Lee Gruner, Clinical Member (Medical administration)
  - Ms Rebecca James (Consumer representative)
  - Dr Matt McConnell, Clinical Member (Public health)
  - Dr Bev Rowbotham, Clinical member (Pathology)
  - Professor Nick Talley, Clinical member (Medicine)
  - Dr Megan Keaney, Department of Health (ex-officio)
Taskforce’s vision for the Review

To ensure that the Medicare Benefits Schedule provides affordable universal access to best practice health services that represent value for both the individual patient and the health system

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system
The Taskforce – our role

- Recommendations to drop or change items
  - Focus on existing items, but the Taskforce may recommend new items or services
  - For example:
    - Existing item/s combined to form new item/s to better describe the service
    - Detailed review using rapid review approach – for existing items and new services
    - Where good clinical practice requires addition of a service, Minister might ask MSAC for expedited advice
    - For a completely novel treatment or technology, Minister might choose a full MSAC review of the evidence
  - Rapid reviews by Clinical Committee may reduce the amount of time required for MSAC
  - Interim Report – submitted to Minister in January

- What is not our role
  - No savings target – however there is scope for reinvestment. This is a matter for the Minister.
  - Divisions of responsibilities between Governments – Federation White Paper
  - Innovative funding models for chronic and complex – Primary health care advisory group
The Taskforce – work to date

- Late 2015 we conducted online consultations and a series of stakeholder forums, including with health consumers

- Key issues for clinicians:
  - Modernisation of items and services
  - More dynamic and responsive to changing clinical practice
  - Reduced complexity and ambiguity

- What this means for patients:
  - More evidence-based care
  - Increased access to valuable, yet under-utilised treatments
  - Prevention of unnecessary treatments and tests
  - More appropriate referrals and appointments
  - Adoption of new, best-practice health care technologies
Review methodology

- Clinician-led review and significant consultation with stakeholders
  - Clinicians
  - Consumers
  - Patient advocates
  - Other health disciplines, including public health

- Clinical Committees
  - Discipline-specific clinical committees
  - Subordinate working groups for reviews of particular items
  - Membership is broad-based: clinicians, requestors, generalists, academics with public health and health economics expertise, consumers
First tranche of Clinical Committees were established in September 2015.

These committees are responsible for 1,100 MBS items – just under 20 per cent of the total:

- Diagnostic Imaging – reviews of bone densitometry, imaging for pulmonary embolism and acute deep vein thrombosis, and imaging of the knee
- Ear, Nose and Throat Surgery – reviews of tonsillectomy, adenoidectomy and grommets
- Obstetrics
- Thoracic Medicine – reviews of sleep studies and respiratory function tests
- Gastroenterology – reviews of upper and lower GI endoscopy
- Pathology (existing committee with expanded membership)

Overall, impressed with number and quality of nominees, robust discussions at meetings, and leadership of Chairs

Approximately 25 more groups will be established over 2016 in each discipline
Clinical Committees – second tranche

- More clinical committees being established with Chairs selected.
  - Cardiac Services (Dr Richard Harper)
  - Dermatology, Allergy, and Immunology (Dr Steve Shumack)
  - Endocrinology (Professor Jonathan Serpell)
  - Intensive Care and Emergency Medicine (Dr Sally McCarthy)
  - Oncology (Dr Bruce Barraclough)
  - Renal Medicine (Professor Alan Cass)
Clinical Committees are following a consistent five-step approach

1. Triage
   - Conduct rapid evidence reviews and targeted analyses as needed for each item

2. Evaluation
   - Examine item descriptors and usage patterns to identify items requiring detailed investigation

3. Recommendation
   - Propose changes to items and articulate rationale

4. Consultation
   - Taskforce finalises recommendation to Minister, and if approved, changes are incorporated into MBS items

5. Inclusion
   - Colleges, peak bodies and other affected stakeholders are notified of the recommended changes and invited to contribute feedback
The Role of the Clinical Committees and Working Groups

Clinical Committee: Initial Triage

- Do the MBS items in scope properly reflect services provided by the specialty group?
- Are some items obsolete and should be removed from the MBS?
- Do some items require a detailed review because of concerns that the service is:
  - Overused, underused, misused
  - Unsafe?
  - Superseded by a better service?
- Are there items that do not need a detailed review but should be revised? For example, consolidated?
- Are there MBS rules related to the speciality that should be reviewed?

Detailed Reviews

- Confirm Research question
- Consider rationale
- Rapid Review of evidence
- Discuss options and implications
- Agree draft recommendation:
  - Revised item descriptor, notes
  - Item consolidation
  - Item replacement
  - Revised fee / fee relativity
The committee advises on matters related to the legislation and regulation underpinning the MBS

Chair by Professor Michael Grigg with broad-based clinical membership

Aim to reduce complexity of the MBS

Some specific examples the committee will examine:

- MBS item descriptors: how can MBS items be described more consistently, clearly defined, and user friendly?
- Multiple services rules
Consultations

- Public consultation on recommendations from Clinical Committees.
  - Recommendations including obsolete items, rapid reviews, changes to existing items, new services
  - Detailed information to provide context and rationale
  - Targeted consultation by directly contacting organisations with relevant interest
  - Broad consultation by publishing on website, media release, and newsletter

- Taskforce considers recommendations from Clinical Committee and feedback from public consultation, prior to making recommendations to Minister.
23 MBS items have been identified by Clinical Committees as obsolete.

These are not a final position. They were released publicly for further consultation.

The feedback will be considered by the Taskforce and recommendations will be made to the Minister.

Diagnostic Imaging: 58706, 58924, 59503, 59715, 59736, 59760, 61465

Ear, Nose, and Throat Surgery: 11321, 18246, 41680, 41695, 41758, 41761, 41846, 41849, 41852

Gastroenterology: 13500, 13503, 30493, 32078, 32081

Obstetrics: 16504

Thoracic Medicine: 11500
How to get involved and be informed

- Clinical Committees and working groups – nominate to participate
- Consultations – opportunities to provide feedback on specific and general issues
- Forums – targeted at clinicians, organisations, consumers, public
- Newsletter – subscribe to be kept informed
- Email: MBSReviews@health.gov.au
Item 6.9 Next College Presentations

CPMC Business Plan 2015-17 at action 1.3 is aimed at providing an opportunity for members to share information and network with ‘profession observers’.

This meeting will feature two presentations on the workforce theme from the perspectives of under-supply and potential over-supply.

At the November 2015 all members agreed on the following additional potential topics:

- Revalidation
- Dual training
- How well Colleges conduct appeals processes within education
- Why Indigenous GP trainees are failing to complete training

In relation to revalidation there are two Colleges who have previously been asked to prepare presentations, the RACP and the RCPA.

**Recommendation:** Members are invited to select 2 and nominate to present them.

**FOR DECISION**
Item 8: Next Meeting

The Committee of Presidents of Medical Colleges will next meet on Thursday 2 June, 2016 at the Royal Australasian College of Surgeons, Spring Street, East Melbourne commencing at 9am.

College Presidents will proceed to dinner the evening prior on Wednesday 1 June, 2016 at 7pm for seating by 7:30pm.