# AGENDA

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<tr>
<th>Item #</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Presented by</th>
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<tr>
<td><strong>Professions Forum (Open)</strong></td>
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<td>8:30am</td>
<td>Tea – coffee on arrival</td>
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| 1 | 9AM | **Meeting formalities 117th MEETING**  
1.1 Attendance and Apologies  
1.2 Conflicts of Interest and Confidentiality  
1.3 Other issues: | Chair | |
| 2 | | **Forum Reports** | Chair | |
| 2.1 | 9AM | Committee of Presidents of Medical Colleges | Prof. N Talley | Verbal |
| 2.2 | 9:10 | The Australian Medical Council | Prof. J Sewell  
CEO: Ian Frank | ✓ |
| 2.3 | 9:20 | Commonwealth Chief Medical Officer | Prof. B. Murphy  
Dr A. Singer | ✓ |
| 2.4 | 9:40 | National Health & Medical Research Council  
Apology | Prof. Anne Kelso | |
| 2.5 | 9:50 | Medical Board of Australia & AHPRA | Dr J. Flynn  
CEO M. Fletcher | ✓ |
| 2.6 | 10AM | Australian Indigenous Doctors’ Association | Dr Kali Hayward  
Mr Craig Dukes | ✓ |
| 2.7 | 10:10 | Australian Commission on Safety & Quality  
in Healthcare | Prof. Villis Marshall | ✓ |
| 2.8 | 10:20 | The Australian Medical Association | CEO Anne Trimmer | ✓ |
| 2.9 | 10:30 | Medical Deans of Australia & New Zealand | Prof Glasgow  
Ms Carmel Tebbutt | ✓ |
| 2.10 | 10:40 | Confederation of Postgraduate Medical  
Education Councils | Prof. Richard  
Tarala | Verbal |
| 2.11 | observer | Australian Medical Student Association | Rob Thomas | Verbal |

11.00 – 11.30am  
Morning Tea for Profession Observers, College Presidents and CEOs
### Colleges Only Session

<table>
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<tr>
<th>3</th>
<th>Governance Session (may be covered over dinner)</th>
<th>Prof Talley</th>
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<tr>
<td>3.1</td>
<td>Minutes from 116th meeting + actions list</td>
<td>For approval</td>
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<td>3.2</td>
<td>Executive minutes 6th February</td>
<td>For noting</td>
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<td>3.3</td>
<td>Chair report</td>
<td>For noting</td>
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<td>3.4</td>
<td>CEO report</td>
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<td>3.5</td>
<td>Financial statements</td>
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<td>3.6</td>
<td>Chair-elect</td>
<td>Vote</td>
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<td>3.7</td>
<td>Constitutional Review</td>
<td>Discuss</td>
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<td>3.8</td>
<td>Reporting against strategic plan</td>
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<th>4</th>
<th>Guests</th>
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<td>4.1</td>
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<tr>
<th>5</th>
<th>LUNCH</th>
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<td>Strategy</td>
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| 5.1 | Indigenous | Prof Stewart | ✓ |
| 5.2 | Rural Health | Prof Truskett | ✓ |
| 5.3 | Revalidation Update | For Discussion | ✓ |
| 5.4 | Senate Medical Complaints Enquiry | For discussion | ✓ |
| 5.4.1 | Report into Medical Complaints | For noting | ✓ |
| 5.4.2 | New Enquiry into Complaints Mechanisms | Discuss | ✓ |
| 5.5 | NRAS legislation background and engagement | For noting | ✓ |
| 5.6 | Health workforce – Departmental submission | For approval | ✓ |
| 5.7 | Healthier Medicare update | For Noting | ✓ |
| 5.8 | PHI Review update | Prof Truskett | ✓ |

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<tr>
<th>6</th>
<th>Other Business</th>
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<td>6.2</td>
<td>Media reporting on Colleges (refer 4.2)</td>
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<td>6.3</td>
<td>Choosing Wisely report</td>
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<td>6.4</td>
<td>Environment &amp; Population Health</td>
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| 7 | Meeting Evaluation | verbal |

| 8 | Next Meeting: 25 May 2017 in Canberra | verbal |
# Council of Presidents of Medical Colleges

**117th Meeting**

16 February 2017 at 9am  
Royal Australasian College of Surgeons, 254 Spring Street, Melbourne

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**11.00 – 11.30am**  
Morning Tea for Profession Observers, College Presidents and CEOs
CHIEF MEDICAL OFFICER’S REPORT

COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

16 February 2017
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Health Workforce Planning and National Medical Training Advisory Network

Key Points
- The National Medical Training Advisory Network (NMTAN) advises Health Ministers on issues relating to planning, distribution and coordination of medical training.
- From 1 January 2017, the Commonwealth Chief Medical Officer Professor Brendan Murphy has been appointed as the new chair of NMTAN replacing Prof John Horvath who completed his tenure last year.
- The first NMTAN meeting of 2017 is scheduled for 17 February 2017 in Melbourne. It is expected to be a focussed meeting which will include a facilitated discussion on NMTAN’s strategic direction to address supply and distribution issues.
- Discussion on the number and distribution of medical school places is another key agenda item of the meeting which was announced by then Assistant Minister for Rural Health, the Hon Dr David Gillespie MP, in December 2016.
- NMTAN continues to work towards completion of demand and supply modelling future reports on specialist medical workforce which currently includes emergency medicine, dermatology, ophthalmology and obstetrics and gynaecology. These reports will be submitted for endorsement at its June meeting.
- The Council of Presidents of Medical Colleges (CPMC) is an active contributor to NMTAN through its President, who attends the Executive Committee meetings.
- In 2015, due to an overlap in the functions of the Medical Training Review Panel (MTRP) and the NMTAN, the then Minister for Health and the Prime Minister agreed for the MTRP to cease meeting and for the department to proceed with work towards repealing Section 3GC of the Health Insurance Act 1973 to abolish the MTRP. The repeal of the MTRP was also announced as part of 2015-16 Mid-Year Economic and Fiscal Outlook. The bill is expected to be introduced to Parliament in the Autumn 2017 session.
- The report on medical education and training will continue to be published under the auspices of NMTAN which has agreed to undertake the functions of MTRP.

Background
The establishment of NMTAN was approved on 10 August 2012 by the Standing Council on Health as a mechanism to enable a nationally controlled medical training system in Australia.

NMTAN was established in February 2014. It provides advice to Health Ministers on issues relating to the planning, distribution and coordination of medical training and medical training plans across the medical training pipeline from university to vocational training.

The department provides Secretariat support to NMTAN. The operations of the NMTAN include two levels of activity:
- the NMTAN Executive Committee; and
- Standing Subcommittees.

The MTRP report on medical education and training is compiled by the department as soon as practicable after 30 June each year. Section 3GC (5) of the Act requires the Minister for Health to table a copy of the report before each House of the Parliament. MTRP has already ceased to meet and the development of the report is currently being guided by NMTAN.
Specialist Training Program (STP)

Key Points

- The department is preparing a final report of the review of the STP for the Minister, setting out the findings and possible reforms to the program for his consideration. This followed the release of a draft Findings Report in September 2016 on the review of the STP and the Emergency Medicine Program (EMP) to all key stakeholders for comment and subsequent discussions with specialist medical colleges and jurisdictions about possible amendments to the draft proposals. The report is expected to be finalised in the first half of 2017.

- Funding arrangements from 2018 onwards will be determined once the current Minister has considered the final report of the department’s review of the STP and EMP.

- The STP was expanded in the 2015-16 MYEFO with an additional 100 STP posts in rural areas over two years under the Integrated Rural Training Pipeline (IRTP) measure. Fifty posts have been allocated for 2017 with a further 50 to be allocated for 2018. These new rural places will increase the total number of ongoing STP places to 1,000 by 2018.

- The department has consulted with the specialist colleges about proposed IRTP models of training. This is focused on ensuring the new places meet the policy objectives of this new measure to develop extended models of specialist training in rural and regional areas on a “rotate in” rather than “rotate out” basis. On this basis, new positions must be designed to enable a trainee to complete the majority of their training within a rural region (at least two thirds of total Fellowship training).

- Ministerial approval has been granted for the allocation of the first tranche of 50 new rural specialist training places to the 10 colleges participating in the IRTP-STP in 2017.

- The response from colleges has been positive and the department expects to be able to fill almost all of the 50 places allocated for 2017 and achieve a reasonable national distribution.

- It is expected that once they are established, regional training hubs will be able to play a support role in the delivery of the IRTP–STP in the future.

- The department recently conducted a trial online Expression of Interest (EOI) process for training settings to register their interest in hosting a training post under the STP, EMP and/or the IRTP. The web-based EOI round was open for a period of four weeks during November 2016.

- The EOI process showed strong demand for future training places, with 623 applications received, including 112 for IRTP-STP places. The EOI process will be used to fill vacant training posts in the STP and to assist colleges identify potential training posts for the IRTP-STP.

- The EOI process includes jurisdictional assessment of each EOI. The department has developed assessment guidelines to assist jurisdictions and colleges to rate the suitability of applications to host STP trainees submitted via the EOI process.

Background

The IRTP MYEFO measure added 100 places to the STP, developed the creation of regional training hubs and established a Rural Junior Doctor Training Innovation Fund.
Regional Training Hubs

Key Points

- As an essential part of the Integrated Rural Training Pipeline, up to 30 new regional training hubs will be formed to support the coordination of rural training opportunities across the different stages of medical training (from undergraduate through to vocational training).

- Regional training hubs are being selected through a competitive process – a targeted Request for Proposal (RFP) was released on 11 October 2016 and it invited the 18 universities participating in the Rural Health Multidisciplinary Training (RHMT) program to apply for funding. A key priority will be to ensure broad geographic distribution of regional training hubs across Australia. The application period closed on 22 November 2016. The department will provide advice to colleges on the location of the hubs once the outcome of the RFP is finalised.

Background

The hubs will be based at existing RHMT program sites and will utilise existing physical and educational infrastructure available through the network of 12 University Departments of Rural Health (UDRHs) and 18 Rural Clinical Schools (RCSs).

The hubs will be expected to work with a range of stakeholders including the specialist medical colleges and those implementing the Rural Junior Doctor Training Innovation Fund to foster integrated medical training pathways for students within regions.

Funding will primarily be available for universities to engage additional staff to implement the initiative. The hubs will work with medical professional groups and employers (hospitals and general practice) to enable students to continue rural training beyond university into postgraduate medical training, helping to identify available places and match students with appropriate training opportunities across the various medical specialties.
Rural Junior Doctor Training Innovation Fund (RJDTIF)

Key Points

- The 2015-16 MYEFO created the Rural Junior Doctor Training Innovation Fund (RJDTIF) to fund rural primary care rotations for first year junior doctors undertaking their internship in a rural area. The primary care rotations will integrate with the IRTP and build on the rural training networks for junior doctors that are funded by the states and territories.

- Approximately 60 FTE places will be supported each year, comprising around 240 rotations (10-12 weeks) into primary care settings. Over $10 million per annum will be provided from 2017-18, with places commencing in 2018.

- The approach to market is expected to open early in 2017. This will allow the development of innovative primary care rotation models and coordination with states and territories before the internship process begins for 2018.

Background

The IRTP MYEFO measure added 100 places to the STP, developed the creation of regional training hubs and established a Rural Junior Doctor Training Innovation Fund.
National Rural Health Commissioner

Key Points

- The Australian Government announced its commitment to establish a National Rural Health Commissioner (the Commissioner) during the 2016 election. The Commissioner will work with regional, rural and remote communities, the health sector, universities, specialist training colleges and across all levels of government to improve rural health policies and champion the cause of rural practice.

- The Commissioner’s first priority is to develop a new National Rural Generalist Pathway to improve access to training for doctors in regional, rural and remote Australia, and report back to Government on a pathway to reform.

- While the Commissioner’s first priority is the development of a medical generalist pathway, the Commissioner’s role will be much broader and will include consultation with stakeholders to also give consideration to the nursing and allied health needs in rural and remote Australia.
  - A Bill to establish the appointment of the Commissioner as a statutory officer, will be introduced during the 2017 Autumn sitting period.
Antimicrobial Resistance

Key Points:

- Antimicrobial resistance is a global health priority that needs immediate action. Resistance to antibiotics has been documented in all regions of the world, including Australia.
- Overuse of antibiotics has been identified as the single most powerful contributor to the development of resistance.
- Internationally, the prominence of antimicrobial resistance as a global health issue has, this year, attracted the attention of the G20, the G7 and the United Nations General Assembly, in addition to being a regular item at the World Health Assembly, OECD and other global forums.
- In June 2015, the Australian Government released the first National Antimicrobial Resistance Strategy. The Strategy takes a One Health approach to coordinate efforts across human and animal health, agriculture and food sectors to reduce antimicrobial resistance.
- The Strategy outlines priority actions across seven objectives, including communication, education and training; infection prevention and control; antimicrobial stewardship; surveillance; research and development; international engagement; and governance.
- In November 2016, the Australian Government released an Implementation Plan to support the National Antimicrobial Resistance Strategy.
- The Plan outlines specific focus areas for action and includes activities being undertaken by the Australian Government, state and territory governments, non-government organisations, professional bodies and research organisations to minimise the development of antimicrobial resistance and ensure the continued availability of effective antimicrobials.
- The first report from the national surveillance system for AMR and antimicrobial usage (referred to as ‘AURA’) was released in June 2016.
- All medical colleges are encouraged to familiarise themselves with the National AMR Strategy and Implementation Plan [which are available at www.health.gov.au/amr] and consider what they can do to minimise the development and spread of antimicrobial resistance.

Background:
Antimicrobial resistance occurs when a microorganism, such as bacteria, becomes resistant to an antimicrobial medicine, such as an antibiotic, to which it was originally susceptible. The ability of bacteria to develop resistance was recognised almost as soon as antibiotics were discovered. The overuse of antibiotics has accelerated the process.
Improving immunisation coverage for at-risk population groups

Key Points
• One of the key challenges to improving immunisation coverage is to target immunisation to at-risk population groups. In Australia these include Aboriginal and Torres Strait Islander people, pregnant women and specific age or medically at-risk cohorts.
• For example, we know a number of groups experience a high burden of illness from influenza yet vaccine uptake remains low.
  o Vaccination rates of pregnant women for influenza in Australia are estimated to range from about 7% to 40%.
  o Influenza vaccination rates for Aboriginal and Torres Strait Islander children under five years of age were less than 10% in 2015.
• For the 2017 flu season, the Department of Health is planning additional targeted activities to improve immunisation coverage in at-risk populations.
• The Department of Health is keen to engage and work collegiately with the Colleges to increase uptake of the influenza vaccine in at-risk cohorts for the 2017 influenza season.
• Into the future, the department is keen work with the Colleges on how we can improve coverage in other risk groups, and for other vaccinations, such as pneumococcal and the new shingles vaccine.

Background
The National Immunisation Program (NIP) provides free vaccines to eligible cohorts based on age or other health risk factors.

The influenza vaccination for pregnant women has been supplied free-of-charge through the National Immunisation Program (NIP) since 2010.

In 2012, the World Health Organization Strategic Advisory Group of Experts on Immunization recommended pregnant women as the most important risk group for seasonal influenza vaccination, because of all the risk groups, pregnant women are the most likely to benefit from being vaccinated.

Both maternal and infant benefit from influenza vaccination is now proven, with one case of serious maternal or infant respiratory illness prevented for every five pregnant women who are vaccinated.

Research indicates that predictors of vaccination uptake for risk groups like pregnant women include, believing that vaccination is safe for the infant, having been recommended vaccination by an antenatal care provider, and provision of vaccination at the time of recommendation.

In 2017, the Department of Health is undertaking market research to better understand enablers and barriers for influenza vaccination uptake, particularly amongst at risk cohorts. Targeted activities for the 2017 flu season are planned based on this market research to improve immunisation coverage in pregnant women, Aboriginal and Torres Strait Islander people, and individuals with chronic medical conditions.
Australian National Diabetes Strategy 2016 – 2020

Key Points
- The Australian Government developed the Australian National Diabetes Strategy 2016-2020 (the Strategy) to update and prioritise the national response to diabetes across all levels of government.
  - The Strategy was released on 13 November 2015 by the then Minister for Health.
  - The Strategy contains a number of goals and potential areas for action that provide a range of ideas for implementation to achieve each goal, while recognising the fiscal outlook facing all governments.
- Under the auspices of the Australian Health Ministers’ Advisory Committee (AHMAC), an Implementation Working Group for the Strategy has been established to operationalise each of the Strategy’s goals through the development of an Implementation Plan.
  - The IWG was established in early 2016. The IWG comprises Commonwealth and state and territory government representatives. Consultation on the draft Implementation Plan is planned for early 2017.
  - The Implementation Plan is expected to be endorsed by the AHMAC by mid 2017 and then publicly released.

Background
The Strategy was informed through public consultation and the independent, expert advice of the National Diabetes Strategy Advisory Group.

The primary audience for the Strategy is policy makers at all levels of government. The secondary audience is non-government organisations including national peak bodies, stakeholder organisations and health professional who advocate for and provide education and care for people at-risk of and with diabetes.

Printed copies have been distributed to primary stakeholders and electronic copies are available from the Department of Health’s website.

The AHMAC agreed, at its 2 October 2015 meeting, that an implementation plan for the Strategy would be developed in negotiation with states and territories.

An Implementation Plan is currently being developed by a jurisdictional working group chaired by the Commonwealth Department of Health. The Implementation Plan will guide government planning by identifying priority diabetes-related actions and initiatives to ensure consistency and reduce duplication of effort and investment.
Medicare Benefits Schedule (MBS) Review Taskforce

Key Points
- Second tranche Clinical Committees are finalising reports for public consultation. These include:
  - Cardiac Services Clinical Committee
  - Dermatology, Allergy and Immunology Clinical Committee
  - Endocrinology Clinical Committee
  - Spinal Surgery Clinical Committee
  - Intensive Care and Emergency Medicine Clinical Committee
  - Oncology Clinical Committee
  - Renal Clinical Committee
- Third tranche Clinical Committees and Working Groups have been established. These are:
  - Anaesthetics Clinical Committee
  - Gynaecology Clinical Committee
  - General Practice and Primary Care Clinical Committee
  - Orthopaedics Clinical Committee
  - Diagnostic Medicine Clinical Committee

Background
The Medicare Benefits Schedule (MBS) Review Taskforce was announced in 2015. The taskforce is considering how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The taskforce is clinician-led and there are no targets for savings attached to the review. The taskforce recommendations are made to the Minister.

The Taskforce consults with practitioners, consumers and professional medical colleges prior to finalising recommendations.
My Health Record Update

Key Points

- In 2016, trials of participation arrangements in the My Health Record were undertaken, including of an opt-out system where individuals in Northern Queensland and the Nepean Blue Mountains areas had a My Health Record automatically created for them unless they chose not to have one. In these trials, 1.9 per cent of individuals across both trial regions advised of their decision not to have a My Health Record created for them. This opt-out rate is in line with international experience with opt-out systems for electronic health records. As a result of the trials, over 970,000 new My Health Records were created across both opt-out trials in June 2016.

- Trials of innovative approaches for increasing participation and use of the system utilising the current opt-in arrangements were also conducted in western Victoria (Ballarat) and Western Australia during 2016.

- All trials have been independently evaluated against the current opt-in participation arrangements operating in the rest of Australia. The outcomes of the evaluation will inform the development of a proposal for consideration by Government in early 2017 about optimal approaches to bringing forward the benefits of increased participation and use of the My Health Record nationally.

- Key My Health Record statistics:
  - As at 15 January 2017 there were nearly 4.5 million individual records and over 9,600 healthcare organisations registered in the My Health Record system, including 5,945 general practices, 872 public and private hospitals and 1,278 pharmacies.
  - 527,706 shared health summaries, 716,225 hospital discharge summaries, 170,358 event summaries and 7,266,077 prescription and dispense records have been uploaded to the My Health Record System.

Background

My Health Record is Australia’s national digital health record system. A My Health Record is a personally controlled digital health record that can be shared securely online by the individual and registered healthcare providers involved in their care. A person’s My Health Record can include important information about their health such as medications, allergies and adverse reactions, medical conditions and treatments, immunisations and advance care plans. Currently, the system is opt-in for individuals and healthcare providers which means they need to register to participate.

The improved sharing of health information between healthcare providers and their patients, including through systems such as the My Health Record, can lead to improved health outcomes including fewer adverse drug events and less avoidable hospital admissions, and a more efficient functioning health system e.g. through reduced duplication of medical tests.
Pharmacy Trial Program

Key Points

- The Australian Government has provided $50 million through the Sixth Community Pharmacy Agreement for the Pharmacy Trial Program (PTP). The PTP will trial new and expanded community pharmacy programs which seek to improve clinical outcomes for consumers and/or extend the role of pharmacists in the delivery of primary healthcare services through community pharmacy.

- It is intended that a particular focus of community pharmacy programs, including the PTP, will be on activities and services which benefit Aboriginal and Torres Strait Islander peoples, and consumers in rural and remote areas.

- Under Tranche 1 of the PTP, the Pharmacy Guild of Australia is leading the following trials:
  - improved medication management for Aboriginal and Torres Strait Islander peoples through pharmacist advice and culturally appropriate services;
  - pharmacy based screening and referral for diabetes; and
  - improved continuity in the management of patients’ medications when they are discharged from hospital.

- Tranche 2 of the PTP involves an open, competitive process. The department called for applications for funding of trial proposals that address the following four priorities:
  - community pharmacist outreach to residential aged care facilities;
  - medicines management and medicines reconciliation services;
  - disease management for appropriate conditions; and
  - screening and referral by pharmacists for cardiovascular risk.

- Applications closed on 15 December 2016 and are currently undergoing assessment.

Background

The Pharmaceutical Benefits Scheme Access and Sustainability Package is a group of measures which will deliver funding for community pharmacy through the Sixth Community Pharmacy Agreement (Sixth Agreement).

The total funding allocated for community pharmacy programs is $1.26 billion over five years, (2015-16 to 2019-20). This includes:

- $613 million to support community pharmacy programs that are continuing from the Fifth Community Pharmacy Agreement and which are assessed as clinically and cost effective;
- $50 million to support a new PTP. This program will fund a number of trials to improve patient outcomes, and seeks to expand the role of pharmacy in delivering a wider range of primary healthcare services; and
- $600 million to support a range of new and/or expanded programs, based on the recommendations of an independent health technology assessment body such as the Medical Services Advisory Committee about the outcomes of trials.
National Health Genomics Policy Framework

Key points:

- The potential for genomics for Australia’s health system is considerable – we are already able to diagnose diseases and detect variants far more precisely and tailor treatment to reflect a person’s wider genetic make-up and better identify those at high risk genetically of inherited disease.
- The Commonwealth and states/territories have a responsibility to integrate rapidly developing genomic technologies into Australia’s health system to harness the potential benefits for better health outcomes.
- A National Health Genomics Policy Framework (the Framework) is being developed which will guide the areas for priority action.
- There is an opportunity for the medical colleges to provide input to the development of the Framework either through written submissions or by participating in a stakeholder forum.
- As of January 2017, a draft Framework has been developed and is available online for public consultation. A series of consultation forums will be held in capital cities over February to March 2017 to complement the online submission process (refer https://consultations.health.gov.au/genomics/national-health-genomics-policy-framework/). The consultation process closes on 8 March 2017.
- A further update will be provided to the Council of Presidents of Medical Colleges after the Framework is approved by the COAG Health Ministers Council later in 2017.

Background
In March 2016, AHMAC agreed that the Commonwealth would lead a project, in consultation with jurisdictions, to develop a national whole-of-governments system-focussed policy framework for genomics.
Implementation of Health Care Homes (HCHs)

Key Points

- The first stage of the HCH model will be rolled out in 10 Primary Health Network regions across the country.
- General practices, Aboriginal Community Controlled Health Services and eligible nurse-led practices in these regions can apply to become a HCH. The selection process is expected to be completed by March 2017.
- Australian General Practice Ltd has been engaged to develop guidelines and educational resources, including training tools for Primary Health Networks and medical practices. Primary Health Networks will be resourced to deliver training to HCHs.
- Clinical leaders from the medical colleges can play an important role in supporting members and raising awareness of the HCH model.

Background

- Up to 200 HCHs will offer services to up to 65,000 people with two or more complex and chronic conditions who have been assessed as being able to benefit from team based care.
Medical Board of Australia and AHPRA report to the meeting of the CPMC on 16 February 2017

Revalidation

The Medical Board of Australia (the Board) has recently concluded a round of consultation on its Expert Advisory Group's (EAG) interim report.

The EAG's interim report proposes a ‘two by two’ approach to revalidation in Australia:

- Two parts: Strengthened CPD + proactive identification and assessment of ‘at-risk’ and poorly performing practitioners.

The core features of the proposed approach are:

- Strengthened CPD: Evidence-based approaches to CPD best drive practice improvement and better patient healthcare outcomes. Strengthened CPD, developed in consultation with the profession and the community, is a recommended pillar for revalidation in Australia.
- Identifying and assessing at-risk and poorly performing practitioners: A small proportion of doctors in all countries are not performing to expected standards at any one time, or over time. Another group of practitioners is at risk of poor performance. Developing accurate and reliable ways to identify practitioners at risk of poor performance and remediating them early is critical, with considerable transformative potential to improve patient safety. It is equally critical to identify, assess and ensure there is effective remediation for practitioners who are already performing poorly.

The public consultation closed at the end of November 2016 and more than 1000 individual doctors provided feedback via the Board's new online discussion forum and by completing the online feedback survey. An additional 116 formal submissions were received. Professor Farmer, Chair of the EAG and Dr Joanna Flynn, Chair of the Medical Board of Australia, met with the specialist colleges and the Australian Medical Association. Stakeholder forums held in each state and territory were attended by more than 400 stakeholders.

The Board’s Consultative Committee met in December and discussed the feedback from the stakeholder meetings and the themes identified in the consultation responses. The Consultative Committee, which is chaired by Dr Flynn, includes community representatives, representatives of the CPMC, the Australian Medical Council, the Australian Medical Association, Medical Deans Australia and New Zealand, the Australian Indigenous Doctors’ Association, the Health Workforce Principal Committee of the Australian Health Ministers’ Advisory Committee, AHPRA, the Medical Council of New South Wales, health complaints entities, pre-vocational training organisations and professional indemnity insurers.

The EAG is now reviewing the submissions and is scheduled to meet in February 2017 to discuss the consultation feedback and the advice from the Consultative Committee as they consider options for piloting proposed approaches to revalidation. The EAG is due to report to the Board in mid-2017, after which the Board will make a decision about future directions.
The Board appreciates the time taken by colleges to attend the stakeholder meetings and the useful feedback that these discussions with college representatives provided. The Board will continue to seek CPMC’s input as this work progresses.

The consultation submissions and the discussion forum comments are published on the Board’s website under ‘Past consultations’.

Social research

The report of the independent social research which the Board commissioned as part of its work on revalidation has now been published.

The social research was designed to help the Board understand what the public expects doctors to do to demonstrate ongoing fitness and competence, and what medical practitioners believe they need to do to maintain and enhance their knowledge and skills.

The research analysed feedback from 3,000 doctors and 1,000 members of the community. It found that doctors are the most trusted profession in Australia but there were some gaps between what doctors do now, and what the community expects. Key findings include:

- 90 per cent of the community trust doctors and nurses, 85 per cent trust pharmacists and seven per cent trust politicians
- doctors and the community agree that the most important attributes for building confidence and trust with patients are effective communication and doctors explaining their diagnosis and treatment
- 39 per cent of doctors and 72 per cent of the public think doctors’ practice should be reviewed at least every five years, and
- 40 per cent of doctors and five per cent of the public think doctors should only be reviewed if there are concerns about their practice.

Most doctors say they are doing a range of continuing professional development (CPD) activities, but less than half reported being involved in clinical audit or peer review. Almost all are confident they are maintaining their professional competence.

Sixty-two per cent of doctors thought that all doctors should be reviewed from time to time, and 20 per cent disagreed.

The social research report is available on the Board’s Past Consultations page under ‘Revalidation’. The report is being considered by the EAG and will help further inform the EAG’s recommendations about revalidation and the Board’s decision-making.

Actions arising from the Snowball review

One of the recommendations in the Snowball review of the National Registration and Accreditation Scheme that was accepted by Health Ministers was that the Medical Board ‘to evaluate and report on the performance of specialist colleges in applying standard assessments of international medical graduate (IMG) applications and apply benchmarks for timeframes for completion of assessments’.

Colleges have been reporting their specialist pathway activity directly to the Board since 1 July 2014. Reporting is annual by calendar year. Colleges are currently submitting their data for the second full calendar year of reporting (1 January – 31 December 2016) (data are due 28 February 2017). The 2015 data have been collated and published and are available on the Board’s website.

The Board appreciates the colleges’ assistance collating the data so it can be published, in the interests of transparency and accountability.

Specialist college performance benchmarks

In 2016, the Board in consultation with colleges developed performance benchmarks that colleges are expected to meet in their assessment of specialist IMGs. The next specialist pathway data report with the 2016 data will include college performance against the benchmarks.
External review of specialist college performance in relation to assessments of international medical graduates

The Board has committed to appoint an external provider to undertake a review of specialist colleges’ performance. The review will be based on the Board’s Good practice guidelines for the specialist international medical graduate assessment process which define the elements of good practice in the assessment of specialist IMGs.

The procurement process to select a provider is currently being finalised. The procurement documents will be published and providers will be invited to submit their bids to undertake the review.

The Board has not specified the methodology for the review, other than it must cover all sixteen colleges and include quantitative elements (college performance against the benchmarks the Board has set) and qualitative analysis to determine how colleges’ processes align with the Board’s Good practice guidelines including the:

- extent to which the college assessment considers the IMG’s training, assessment, experience, recent practice and CPD when assessing comparability
- college committee structure
- interview and assessment procedures and processes
- fees
- appeals processes.

The procurement documents for the review explicitly state that college processes that do not directly relate to specialist IMG assessments are out of the scope of the review. For example, the review will not look at college processes such as:

- historical specialist IMG assessment processes
- overseas trained doctors who have been accepted into the full college training program
- training pathways for Australian and New Zealand medical graduates.

The reviewer will be visiting each college in person and will meet with college representatives as part of the review. The reviewer will also seek input from external stakeholders including IMGs and employers.

The Board has also asked that the reviewer evaluate the current data collection and benchmarks and make any recommendations for future monitoring. The reviewer will also be asked for any recommendations about whether elements of the current IMG assessment process could be improved.

It is expected that the successful bidder will be appointed in the next few months and the review will largely be undertaken in 2017.

Medical Council of New Zealand and Medical Board of Australia – joint meeting with specialist colleges

On Friday 3 February 2017, the Medical Council of New Zealand and the Medical Board of Australia held a joint meeting with the specialist colleges. Over 90 people attended and a range of issues were discussed including:

- revalidation
- cultural competence
- bullying and harassment
- assessment of specialist international medical graduates and the external review commissioned by the Medical Board.

Attendees agreed that a further joint meeting in 12 – 18 months time would be useful.
Senate inquiry into medical complaints

In November 2016, the Senate Community Affairs References Committee tabled its report of the inquiry into the Medical complaints process in Australia. The committee made a number of recommendations for hospitals, specialist colleges and universities to address bullying and harassment.

The committee also recommended that a new inquiry be established. The terms of reference for the new inquiry, Complaints mechanism administered under the Health Practitioner Regulation National Law are:

- the implementation of the current complaints system under the National Law, including the role of AHPRA and the National Boards
- whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints
- the roles of AHPRA, the National Boards and professional organisations, such as the various Colleges, in addressing concerns within the medical profession with the complaints process
- the adequacy of the relationships between those bodies responsible for handling complaints
- whether amendments to the National Law, in relation to the complaints handling process, are required, and
- other improvements that could assist in a fairer, quicker and more effective medical complaints process.

The Committee is accepting submissions until 24 February 2017 and is due to report on 10 May 2017. More details are available on the Senate Committee webpage.

The Board already has committed to taking action on bullying and harassment by:

- strengthening the Board’s Good medical practice - a code of conduct for doctors in Australia about bullying and harassment and making the standards of acceptable behaviour for doctors clear
- taking the lead in developing and implementing a national, annual survey of trainees which will give them a voice, be a safe place for them to provide feedback on their training experience and enable systemic issues such as potential hotspots of bullying and harassment to be identified. AHPRA and the Board will work with health departments, employers, medical colleges, and the Australian Medical Council to develop the governance and funding arrangements to make this happen
- commissioning research on vexatious complaints to understand how and why people are driven to make them, and what we can do about it. The data we have now indicate this is a small problem with a big impact when it happens. We will publish what we learn and act on it, and
- strengthening Good medical practice - a code of conduct for doctors in Australia on vexatious complaints and establishing a clear benchmark to enable the Board to take further action about a medical practitioner who makes complaints purely to damage another registered practitioner.

Inquiry into Queensland OHO

The Queensland Government’s Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee has released its report following the inquiry into the performance of the Health Ombudsman’s functions pursuant to section 179 of the Health Ombudsman Act 2013.

The Committee made a number of recommendations in relation to how information about complaints is shared between the Office of the Health Ombudsman (OHO), AHPRA and the National Boards.

The report is available on the Queensland Parliament webpage.
Senate report on Lyme-like illness

In November 2016, the Senate Community Affairs References Committee tabled its report of the inquiry into the Growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients.

The committee made a number of recommendations. The report is available on the Senate Committee webpage.

Tidying up qualifications published on the public register

In the 2016 renewal period, medical practitioners were asked in their renewal to check some of their ‘Register Details’ including their qualification(s) currently recorded on the register and for specialists, confirming their pathway leading to specialist registration. A significant back-end pre-renewal ‘clean-up’ of qualification records occurred where over 179,000 corrections were made to improve both the content and consistency of how qualifications are displayed. In total, 7272 medical practitioners responded for further qualification amendments and a dedicated team was charged with responding to these requests. There are currently only 12 remaining specialist records requiring verification from renewal.

The next stage of this work will see AHPRA continue to work with medical colleges to verify and update its records. This important work helps in maintaining the integrity of the online national register of practitioners and improves the quality of information shared with our stakeholders. AHPRA and the Board appreciates the assistance provided by colleges for this work to date.

Annual report

Each year AHPRA and the National Boards publish an annual report detailing the work of the National Boards over the previous financial year. The report contains extensive data on the National Scheme including registration and notifications data. The 2015/16 annual report was published in November 2016 and is available on the AHPRA website under ‘Publications’.

AHPRA also now publishes state and territory summaries with more information about activities in each state and territory. These are also available on AHPRA’s ‘Annual report’ page under ‘Publications’. A profession specific report will also be published, focusing on the work of the Medical Board over the past year. The report will be available on the Board’s website and a link will be included in the Board’s electronic newsletter which is sent to all registered medical practitioners who have provided an email address.

Dr Joanna Flynn AM
8 February 2017
Australian Indigenous Doctors’ Association
Council of Presidents of Medical Colleges (CPMC) Update – February 2017

AIDA Update for CPMC Meeting
16 Feb 2017

AIDA is dedicated to the pursuit of leadership, partnership and scholarship in Aboriginal and Torres Strait Islander health, education and workforce, and is committed to achieving positive outcomes for Aboriginal and Torres Strait Islander medical students and doctors across the medical education and training continuum. We continue to promote the integration of cultural safety in all aspects of the health system in our ongoing efforts to increase the number of Indigenous medical students and doctors.

Key AIDA updates

1. **AIDA 2017– Family. Unity. Success. 20 years strong**
   
   AIDA’s annual professional networking event, AIDA 2017, will be held in the Hunter Valley from 20 – 23 September 2017.

   With 2017 marking AIDA’s 20th anniversary and following on from the strong involvement of medical colleges in the success of AIDA 2016, we would like to invite all medical colleges to mark the date and continue the high level of engagement, collaboration and support with our organisation. AIDA will contact medical colleges shortly for an expression of interest to deliver a workshop at AIDA 2017, participate in the Growing our Fellows workshop, and consider sponsoring the event.

2. **2016 Pacific Region Indigenous Doctors Congress (PRIDoC)**
   
   The event was held in Auckland, Aotearoa, from 27 November to 1 December 2016 with AIDA represented by six delegates. The conference brought together 250 Indigenous doctors, medical students, health professionals, health researchers and medical educators from around the Pacific to discuss ideas, actions and evidence that are transforming Indigenous health. AIDA’s delegation included President Dr Kali Hayward, Vice President Dr Sean White, founding member Professor Ngiare Brown, student representative Ms Destiny Powell, CEO Mr Craig Dukes and policy officer Mr Wal Dorrington.

   Dr Hayward presented on racism in the health sector and Dr White on the role of doctors in closing the gap. AIDA Indigenous medical student members Mr Ryan Bulger and Ms Louise Richardson also delivered a session on the AIDA Student Representative Committee’s 2016 *Debunking the Myths* project, a video in which senior AIDA members and leaders address some of the challenges Aboriginal and Torres Strait Islander medical students encounter during their university studies.

   The next PRIDoC conference is scheduled for April 2018 in Hawaii and will be hosted by ‘Ahahui o nā Kauka, the Association of Native Hawaiian Physicians.

3. **AIDA Board**
   
   The new AIDA Board held its first meeting in November 2016. New representation roles have been assigned in line with our new board composition. We look forward to continuing our close collaboration with medical colleges and the important work of the committees on which AIDA is currently represented.

4. **NMTAN Working Group with AIDA lead**
   
   The Executive Committee of the National Medical Training Advisory Network (NMTAN) of the Department of Health has asked AIDA to take the lead on and chair a working group tasked with supporting the specialist medical colleges in recruiting and retaining more Aboriginal and Torres Strait Islander specialist trainees. The working group consists of NMTAN Executive Committee members, among those the Chair of the CPMC and a number of Presidents of medical colleges. The NMTAN Secretariat will shortly distribute a project plan to the
working group members. AIDA will be approaching CPMC member colleges in an effort to collate college policies and programs already in place to boost recruitment and retention of Aboriginal and Torres Strait Islander trainees. AIDA will also be in contact with CPMC member colleges to confirm the timelines for their respective 2018 and 2019 intakes. AIDA and the NMTAN working group thank the medical colleges in advance for their support in assisting this important work.

5. Collaboration Agreement Forum (CAF)
A joint application from AIDA, CPMC, Medical Deans and CPMEC to seek financial support from the Commonwealth to establish and manage a new Collaboration Agreement Forum was unsuccessful. AIDA is currently in discussions with its agreement partners to consider the most appropriate way forward.

6. AIDA Policy Statements
Since the last CPMC meeting in November 2016, two further AIDA policy statements have been finalised and published on the AIDA website:


The above position papers, as well as AIDA’s policy statement on the role of doctors in closing the gap from August 2016¹, are all closely linked to AIDA’s overarching policy paper on Cultural Safety². We encourage all CPMC members to read those papers and disseminate them among the membership of their respective colleges.

7. AIDA Submissions
AIDA also continues to provide submissions on issues of importance to Aboriginal and Torres Strait Islander health. Since the last CPMC meeting AIDA provided the following submissions:

- Submission to the redesign of the Practice Incentives Program (PIP) consultation process (https://www.aida.org.au/wp-content/uploads/2015/03/AIDA-submission-to-the-redesign-of-the-Practice-Incentives-Program-consultation-process.pdf);
- Submission to the consultation on the draft Australasian College of Emergency Medicine (ACEM) Accreditation Requirements; and
- Joint submission with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA), and the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) to the Federal Government’s public consultation on the draft Fifth National Mental Health Plan (https://www.aida.org.au/wp-content/uploads/2015/03/Joint-AIDA-CATSINaM-IAHA-and-NATSIHWA-Submission-to-consultation-on-5th-National-Mental-Health-Plan.pdf).

8. Engagement and Representation
- AIDA continues its engagement with specialist medical colleges at the policy officer and management level. In November 2016 we met with ACEM, ACSEP, RACGP and RACS to discuss issues affecting Aboriginal and Torres Strait Islander doctors and continue to improve policy and project collaboration.

• In November, AIDA was represented by CEO Craig Dukes at a follow up meeting from the Redfern statement. Together with AIDA policy staff Anita Mills and Ludger Dinkler, Mr Dukes also attended the Lowitja Institute’s International Indigenous Health and Wellbeing Conference in Melbourne.

• In November and December 2016 AIDA representatives also attended the Medical Deans Annual Conference and the National Rural Health Alliance’s Council Fest. AIDA staff also represented at Information sessions about Health Care Homes, the Ear Disease Roundtable, a Racism in Health Services Workshop, and a Canada-Australia Roundtable on Indigenous Health & Wellness.

• AIDA’s CEO and Policy Officer Raegina Taylor are continuing to progress AIDA’s engagement with student members and Indigenous Support Units at medical universities across the country and are undertaking a series of visits to universities in Melbourne and Wollongong in February.

9. Other Business

• AIDA’s member survey on their experiences of bullying, racism and lateral violence has closed. The survey results are currently being analysed and will inform a second part of the AIDA position statement on Racism in Australia’s Health System. The input of our membership is greatly appreciated and will continue to inform AIDA’s broader policy position in this area.

• An AIDA working group, tasked to scope and develop a cultural safety training resource aimed at doctors, had its first meeting for 2017 at the end of January. The group’s work will continue throughout 2017.

• AIDA continues with ongoing promotion of bursaries, open positions and other opportunities for Aboriginal and Torres Strait Islander medical students and doctors, including the Australian Medical Association’s Indigenous people’s medical scholarship and the Royal Australasian College of Surgeons’ scholarships and awards for Aboriginal and Torres Strait Islander junior doctors and final year medical students.
Australian Commission on Safety and Quality in Health Care
Update on activities

Implementation of the National Safety and Quality Health Service Standards (NSQHS Standards)
Information reported by accrediting agencies on health service organisation assessments for the period January to December 2016 and for assessments scheduled for 2017 has been collated. Below is a summary of information on health service organisation assessments for 2016 and 2017.

2016 assessment data
From January to December 2016, 827 health service organisations were assessed to the NSQHS Standards, of which:
- 395 (48%) were assessed to all 10 NSQHS Standards
- 402 (49%) were assessed to Standards 1 to 3
- 30 (3%) new health service organisations conducted an interim assessment

A final 2016 report will be completed when the final count of assessments is available in April 2017.

Core actions most frequently not met from January to December 2016
The five core actions most frequently not met by private hospitals and day procedure services in 2016 were:
- Participation of clinical workforce in regular performance reviews (Action 1.11.2)
- Reporting of compliance rates from hand hygiene audits (Action 3.5.2)
- Auditing of compliance to aseptic technique (Action 3.10.2)
- Training on patient centre-care and engagement of individuals in their care (Action 2.6.1)
- Increasing compliance to aseptic technique (Action 3.10.3)

The five core actions most frequently not met by public hospitals in 2016 were:
- Reducing risks to patients identified through the incident management system (Action 1.14.4)
- System is in place to define and review the scope of practice for the workforce (Action 1.10.1)
- Minimising risks to patient safety and quality of care (Action 1.5.2)
- Training on patient centre-care and engagement of individuals in their care (Action 2.6.1)
- Consumers providing feedback on patient information publications prepared by the organisation (Action 2.4.1)

2017 scheduled assessments
There are 1,067 organisations scheduled for assessment in 2017, of which:
- 534 (50%) are scheduled to be assessed to all 10 NSQHS Standards
- 511 (48%) are scheduled to be assessed to Standards 1 to 3
22 (2%) are for new health service organisations scheduled to be assessed through an interim assessment.

**Update on version 2 of the NSQHS Standards**

Version 2 of the NSQHS Standards, Decision RIS and the Australian Health Ministers’ Advisory Council (AHMAC) paper were endorsed by the Commission’s Inter-Jurisdictional Committee (IJC) at the 6 October 2016 meeting, and were approved by AHMAC at the 2 December 2016 meeting.

These papers have been submitted to the Council of Australian Governments' Health Council out of session.

**Resources to support version 2 of the NSQHS Standards**

The launch of version 2 of the NSQHS Standards and first round of supporting resources is planned for November 2017, with assessment to the NSQHS Standards to commence from 1 January 2019.

The supporting resources to be launched with version 2 of the NSQHS Standards will comprise the following:

- hospitals safety and quality improvement guide (SQIG)
- hospitals accreditation workbook
- day procedures services guide
- multi-purpose services and small rural hospitals guide
- Aboriginal and Torres Strait Islander health guide
- guide for governing bodies using version 2 of the NSQHS Standards
- consumer resources

The Commission has developed draft versions of these resources to be released for public consultation during March–May 2017. The objectives of the consultations are to:

1. seek comment on the draft resources
2. use advice received to inform revision
3. raise awareness of the resources with key stakeholders before their launch

The consultation dates for the first round of resources are detailed in the following table. The consultations will be staged to manage the burden on stakeholders providing a response.

<table>
<thead>
<tr>
<th>Resources</th>
<th>Consultation dates</th>
<th>Consultation length</th>
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<tbody>
<tr>
<td>Hospitals SQIG and workbook</td>
<td>6 Mar–21 Apr 2017</td>
<td>7 weeks</td>
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<tr>
<td>Hospitals workbook</td>
<td></td>
<td></td>
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<tr>
<td>Aboriginal and Torres Strait Islander health guide</td>
<td>3–28 Apr 2017</td>
<td>4 weeks</td>
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<tr>
<td>Guide for governing bodies</td>
<td></td>
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<tr>
<td>Day procedure services guide</td>
<td></td>
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</tr>
<tr>
<td>Multi-purpose services and small rural hospitals guide</td>
<td>17 Apr–19 May 2017</td>
<td>5 weeks</td>
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</table>

Final drafts of these resources will be submitted to the Commission’s standing committees and Board for approval during the July–August 2017 round of meetings.

A second round of resources will be released for consultation in early 2018, and launched during 2018. These resources will include:

- primary health services resources—these may incorporate content from the existing community and dental resources
online interactive resources, including clinical specific information.

**Australian atlases of healthcare variation**

**Development of the second Atlas**

The second *Australian atlas of healthcare variation* (the second Atlas) is in development and will be published in the first half of 2017. The second Atlas is part of a program of work to map geographical variation in healthcare use across Australia, identify variation that may be unwarranted and recommend actions to reduce unwarranted variation.

The second Atlas will focus on acute hospital services and will include 22 items from the following clinical areas:
- potentially preventable hospitalisations
- maternity and women’s health
- surgery
- cardiovascular conditions; and
- intensive care

Variation for each item will be presented in maps and figures, and data analysis will show variation by socioeconomic disadvantage and remoteness. New for the Atlas, analysis by Aboriginal and Torres Strait Islander status and public/private patient classification will be presented where possible. Analysis and commentary for each data item is currently being developed in collaboration with topic expert groups from the five clinical areas.

As for the first Atlas, development of the second Atlas is being guided by a Jurisdictional Advisory Group and an Atlas Advisory Group. The Atlas Advisory Group is chaired by Professor Anne Duggan and has representation from a number of clinical colleges.

Prior to publication of the second Atlas, Professor Anne Duggan and Commission staff will be visiting colleges and presenting the findings and analysis for discussion. A number of these visits are currently underway and are scheduled to be completed by the end of February 2017.

**Implementation of recommendations from the first Atlas**

The Commission has developed an implementation strategy for recommendations from the first Atlas, which was noted by AHMAC out of session in May 2016. The Commission has made good progress on implementing its recommendations.

**Interactive first Atlas**

An interactive online version of the first Atlas has been developed to build on the existing online format. The interactive form went live in early November 2016 and allows users to manipulate the maps, including zooming and panning, and to interrogate the data behind the map in various ways, such as downloading or exporting open data in various formats.

**Clinical Care Standards**

**Clinical Care Standard pending release**

The Commission has recently completed a Clinical Care Standard for Osteoarthritis of the Knee following a broad public consultation in July 2016 and noting of the work by AHMAC in December 2016. This Clinical Care Standard aims to ensure patients aged 45 years and over with knee pain who are suspected of having osteoarthritis receive optimal treatment. It applies to all healthcare settings where care is provided to patients with knee osteoarthritis. It is scheduled to be launched on 19 May 2017.

**Clinical care standards in development**

The Heavy Menstrual Bleeding (HMB) Clinical Care Standard commenced development with a topic working group in July 2016. A broad public consultation was undertaken in late 2016 and early 2017. The draft aim of the Clinical Care Standard is to ensure that women with heavy menstrual bleeding are offered the least invasive, most effective treatment appropriate to their
clinical needs. The draft scope identifies the Clinical Care Standard is applicable in primary care, and gynaecology practices.

It is expected the final draft of the HMB Clinical Care Standard will be completed in June 2017 and be forwarded to AHMAC for consideration shortly after.

Work has commenced on a clinical care standard on Venous Thromboembolism (VTE). This follows a request from the Commission’s IJC outlining a range of issues associated with this condition - including the assessment of patients admitted to hospital for VTE risk, appropriate prescribing and administration of VTE prophylaxis, and confusion regarding the best-practice use of the new oral anticoagulants. It also follows the rescindment of the NHMRC Clinical Practice Guideline on prevention of this condition. This work is to be fast-tracked and is expected to go to public consultation in the middle of the year and released at the end of 2017.

**National Model Clinical Governance Framework**

The Commission has been engaged by a number of jurisdictions to undertake reviews into patient safety issues. It became evident during these reviews that health service organisations have experienced significant issues with:

- implementing an open disclosure response consistent with national and local standards
- the ability of incident management and investigation systems to provide adequate surveillance for the purpose of recognising significant safety failures or risks
- implementing corrective action in response to identified patient safety risks and failures
- complaints management systems that include a partnership with patients and carers
- ensuring a robust and positive safety culture
- a clear understanding of the roles and responsibilities of boards, executive, clinical teams and clinicians.

In response to these experiences, the Commission has developed a national model clinical governance framework. With advice from an expert advisory panel, and following a review of existing jurisdictional, national and international clinical governance frameworks, the draft *National Model Clinical Governance Framework: Public Health Services* (the Clinical Governance Framework) has been prepared.

The purpose of the Clinical Governance Framework is to ensure patients and consumers receive safe and high-quality health care by describing the elements that are essential for leaders of health service organisations to implement integrated corporate and clinical governance systems.

The Clinical Governance Framework is based on the NSQHS Standards, particularly the Clinical Governance for Health Service Organisations Standard and the Partnering with Consumers Standard.

The definition of clinical governance which underpins the Clinical Governance Framework is as follows:

*Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving.*

*Good clinical governance ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.*

Following review by the Commission’s Board, it is proposed to release the Clinical Governance Framework for public consultation. Feedback from this consultation process will inform the final Clinical Governance Framework, which will be submitted to AHMAC for noting later in 2017.
The Clinical Governance Framework will be supported by additional resources for specific target audiences including members of governing bodies such as boards, clinicians and consumers.

Antimicrobial Use and Resistance in Australia (Aura) Project
The Commission continues to advance work on the development of the Aura Surveillance System, to monitor antimicrobial resistance (AMR) and antimicrobial use (AU) across the eight streams of activities which includes passive and targeted surveillance in the hospital and community settings.

CARAlert — surveillance of critical antimicrobial resistances (CARs)
The CARAlert system, which went live in March 2016, was enhanced in October 2016 to allow authorised users to directly access their state/territory public hospital data directly. The enhancements also replaced the SMS alerts with a weekly email digest report for authorised state, territory and Australian Government recipients.

A report which includes analyses of data for the period 17 March 2016 to 31 October 2016 was published on the Commission’s website in January 2017 (see https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/what-is-aura/national-alert-system-for-critical-antimicrobial-resistances-caralert/). In December 2016 AURA state and territory liaison officers were provided with a copy of the report and a listing of the public hospitals where patients with CARs were cared for in their state/territory.

OrgTrx — passive AMR surveillance
The Commission is continuing to work with Queensland Health, other states and territories, and private pathology providers to expand OrgTRx as the platform for national passive AMR surveillance. Sites where OrgTrx has already been implemented are QLD Health, ACT Health, Monash Health, Royal Hobart, Sydney LHD, South West Sydney LHD and Mater Misericordiae. SA Pathology, SEALS (NSW) and PathWest (WA) will be commencing use of OrgTrx between January and March 2017. The Commission is in discussion with NT Health, private pathology providers, and NSW Health Pathology regarding implementation of OrgTrx at additional sites.

National Antimicrobial Prescribing Surveys (NAPS) — Targeted Hospital AU surveillance
The data collected by the National Centre for Antimicrobial Stewardship for the 2015 Hospital NAPS have been analysed and a report has been published on the Commission’s website following provision of a copy to AURA state and territory liaison officers (see https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/appropriateness-of-antimicrobial-use-the-national-antimicrobial-prescribing-survey-program/?section=4). The 2016 Hospital NAPS data collection closed on 31 January 2017.

Analyses of the 2016 Surgical NAPS electronic pilot data collection and the 2016 Aged Care NAPS are due to be provided to the Commission by March 2017.

National Antimicrobial Utilisation Surveillance Program (NAUSP) — Passive Hospital AU surveillance
The Commission continues to work with SA Health to enhance the web-based Antimicrobial Utilisation Surveillance System (AUSS) software currently used for the NAUSP. A web portal for data entry was activated in May 2016. The second phase of enhancements, which will increase the functionality of data access and report generation for NAUSP contributors, will be activated by the end of the first quarter of 2017.

On 16 December 2016, SA Health de-activated its historical data entry portal. All contributions to NAUSP must now submit data via the new web portal.

The Commission and SA Health are in the process of finalising the report on data collected during 2015. The report will be published on the Commission’s website in February 2017.

**Australian Group on Antimicrobial Resistance (AGAR) — targeted AMR surveillance**

The Commission and AGAR are finalising an amalgam report which summarises key findings of 2015 data collected for the three AGAR Sepsis Outcome Programs – the gram-negative Sepsis Outcome Program (GNSOP), the Australian Enterococcal Sepsis Outcome Program (AESOP), and the Australian Staphylococcal Sepsis Outcome Program (ASSOP). The report will be published in February 2017.


**AURA 2017 Report**

The Commission has commenced the production of AURA 2017 Report (which is modelled on the AURA 2016 Report). Planning for a release date is in progress.

**National Consensus Statement: Essential elements for recognising and responding to deterioration in a person’s mental state**

The Commission has developed a *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person’s mental state* (the Consensus Statement). Deterioration in a person’s mental state can occur in all health settings. There is currently a marked variation in the effectiveness of responses to deterioration in a person’s mental state, both within specialist mental health services, and in the broader health system. Moreover, there is evidence many people who experience a deterioration in mental state are further traumatised by interventions delivered by health services, even when these interventions are implemented within existing national and jurisdictional guidelines.

The Consensus Statement is adapted from the model which has been successfully implemented for recognising and responding to acute physiological deterioration, and described in the *National Consensus Statement: essential elements for recognising and responding to acute physiological deterioration*. This model was based on the evidence that many people experienced preventable adverse outcomes after early signs of physiological deterioration were either not recognised, or not responded to promptly.

The Commission undertook a study in 2014 to investigate the feasibility of adapting the original recognition and response model to mental health care. The report, *Recognising and Responding to Deterioration in Mental State: A Scoping Review* demonstrated there was provisional support among stakeholders for the approach. The Commission then developed a draft of the Consensus Statement through a comprehensive consultation process. The consultation process involved:

- initial testing and validation of the draft Consensus Statement by the Commission’s Mental Health Advisory Group, Recognising and Responding to Clinical Deterioration Advisory Committee and standing committees, including its IJC, Private Sector Committee, and Primary Care Committee
- a roundtable involving people with lived experience of mental health issues, clinicians from mental health and other specialities, health service organisation managers, researchers, policy makers and peak body representatives
• a public consultation process on the draft Consensus Statement, with 32 online and written submissions received from state and territory health departments and other government agencies, local health districts, health services, colleges and professional associations, consumer and carer organisations, private health-based organisations, and individual clinicians and consumers.

The Consensus Statement outlines ten essential elements that provide guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to deterioration in a person’s mental state. The ten elements are divided into three components.

Processes of care:
1. Recognising deterioration in a person’s mental state
2. Escalating care
3. Responding to deterioration in a person’s mental state.

Therapeutic practice:
4. Creating safety and minimising restrictive practices
5. Teamwork and shared decision making
6. Communicating for safety.

Organisational supports:
7. Leadership and governance
8. Workforce development
9. Standardised practices to support high quality care
10. Evaluation and feedback.

The Consensus Statement provides seven guiding principles which describe the philosophy of care underpinning the recognition and response approach to deterioration in mental state. The Consensus Statement describes the values which members of the healthcare workforce practise, including person-centred and culturally competent care. It also outlines how members of the workforce can practise recovery-oriented and trauma-informed care, consistent with contemporary national frameworks in mental health.

The Consensus Statement is designed to support health service organisations to implement version 2 of the NSQHS Standards. During 2017 the Commission will develop resources to support implementation of the Consensus Statement in line with the development of resources to support the NSQHS Standards.
2017/18 Federal Budget Submission

The AMA released its 2017/18 Federal Budget submission on 22 January 2017. It covers the following key areas:

- Medicare Indexation Freeze;
- Public Hospitals;
- Health Care Home;
- Medicare Reviews;
- Medicare Levy;
- Pathology;
- Private Health Insurance;
- Medical Indemnity – Underpinning Affordable Health Care;
- Medical Care for Palliative Care and Aged Care Patients;
- Indigenous Health;
- Mental Health;
- Medical Workforce and Training;
- Obesity;
- Nutrition;
- Physical Activity;
- Alcohol and Drugs; and
- Climate Change and Health.

The AMA Pre-Budget Submission 2017-18 is available here.
Medicare Rebate Freeze

This remains a key advocacy issue for the AMA, with the AMA President having already met with the new Health Minister to discuss this. Out of pocket costs for patients that are privately billed are rising rapidly and we are becoming increasingly concerned that access to services for veterans are becoming more difficult with evidence of a growing reluctance to accept the Department Veterans’ Affairs (DVA) Gold Card. In relation to the latter, DVA fee schedules have been frozen in line with the MBS.

Private Health Ministerial Advisory Committee (PHMAC)

The AMA is represented on the PHMAC, which has broad terms of reference to review aspects of private health including closer examination of PHI product design with simplified consumer products; standard product categories; the role of exclusions and restrictions; appropriate excess levels; and the scope of services covered by PHI.

The PHMAC has met four times. It has focussed on the difficult task of improving value for consumers (increasing what is covered by products without greatly increasing the cost of cover). The Committee has discussed possible operational arrangements of a product design approach that categorises hospital products into Gold/Silver/Bronze tiers according to exclusions and excesses. The Committee considered the minimum product standards and excess levels that could apply under such a scheme, whether insurers should be permitted to apply restrictions and co-payments and the impacts such changes would have on premiums. The Department will has engaged actuarial support to undertake modelling and analysis of product design approaches being considered by the Committee.

Working groups to consider the provision of clear and concise consumer information; improving contracting and second tier default benefits and providing better value for rural and remote consumers have commenced meeting. The clinical definitions working group will commence shortly.

Private Health Insurance Report Card

The AMA Private Health Insurance Report Card is scheduled for release shortly.

Last year’s report highlighted how difficult it is for consumers to navigate the private health system and choose a product that suits their situation.

A major concern at the moment is that private health insurance is not providing value for money
and that negative messages are undermining the private health system. To counter, a theme for this year’s report is improving value.

This year’s report card will highlight for consumers that there are differences in private health insurance policies and the operations of funds. The report provides consumers with indicators to help them choose the right cover for them.

Finally, the report asked consumers to consider carefully what cover they really need, and review their policy to ensure that those needs will be met.

**AMA Public Hospital Report Card**

The AMA Public Hospital Report Card for 2017 is also scheduled for release shortly.

The Report Card presents core data on public hospital performance in a consistent format that enables easy comprehension and comparison over time.

Governments publish voluminous data on hospital performance and activities, often with significant qualifications on data involved, making it but all impossible for the average reader to arrive at a clear picture of performance.

The AMA Public Hospital Report Card uses the latest publicly available information as published by the Commonwealth Government. Based on the published data, the AMA Report Card for 2017 is expected to show that, against key measures, the performance of our public hospitals is virtually stagnant, or even declining.

**National Digital Health Strategy**

The development of a National Digital Health Strategy (NDHS) by the Australian Digital Health Agency (ADHA) is an important and welcome step. The AMA has long and consistently advocated for a strategic plan for digital health.

The AMA also welcomes the commitment by the Australian Digital Health Agency to work with all areas of the community to *co-produce* the NDHS, based on collaboration on the design of future services.

Clearly doctors are ‘mission critical’ to this process and to digital health broadly.

Doctors view digital health as a collective name for a set of clinical tools that should assist the provision of clinical care. They must serve a clinical purpose, fit into the clinical environment, support clinical workflow, and meet ease of use and integration requirements of medical practitioners and practices. This should be clearly acknowledged up front in the NDHS.
The digital health strategy should have a more balanced and complete coverage of doctors’ needs, compared to the historic over-emphasis on patient-controlled health records (My Health Record - MyHR). This must include specific support for medical specialists other than GPs to take up digital health, including but not limited to the MyHR.

**National Maternity Services Framework project**

Late last year, the Federal AMA became aware that the Australian Health Ministers’ Advisory Council (AHMAC) is overseeing a project to develop a public hospital maternity services policy without any input from obstetricians and only minimal input from other medical practitioners.

The AMA has called for this situation to be rectified, calling for the project to be actively informed by an appropriate range of medical practitioners from the specialities of obstetrics, gynaecology, general practice, anaesthetics and psychiatry. The AMA has further highlighted how the creation of a working group without appropriate representation from the profession and consultation from the very beginning is unacceptable.

**MBS Reviews**

The MBS Review Taskforce’s last newsletter update was some time ago, and it is unclear how the work of the clinical committees has progressed since. The Department has advised setbacks in tranche two and three have led to the delays in the release of committee reports. They are expected to be released soon.

The AMA’s position has been to defer clinical committee feedback to the colleges and societies on specific changes proposed. The AMA made a brief submission to the report of the Principles and Rules committee, which has been established to guide the rules and regulations underpinning the MBS.

However, as a result of concerning changes to the MBS review of skin items (which predates the MBS Review Taskforce), the AMA is increasingly concerned about the potential for detrimental outcomes from the broader review. The AMA has invited Professor Bruce Robinson to present at the AMA meeting of medical Colleges, Associations and Societies on 9 March 2017 so as to provide a forum for the profession to seek clarification of progress to date.

**MBS Changes**

The AMA continues to work with relevant craft groups to address the detrimental outcomes to
private health insurance banding classifications applied to the new MBS skin items. A delegation of representatives from relevant groups has met with the Department to highlight concerns, and is now in a process of gathering evidence of how the new arrangements are impacting informed financial consent and out of pocket costs, as well as creating delays and cancellations.

In addition the Department has written to relevant groups to discuss changing the definition of cosmetic services, and noting Government is limited in its ability to recover Medicare benefits paid for services performed only for cosmetic reasons, this definition is likely to impact a number of items currently on the MBS.

The AMA is also aware that the Department plans to disband the Medicare Claims Review Panel (MCRP), whose purpose is to review 26 MBS items that require demonstration of clinical need before Medicare benefits are payable. Again the AMA is aware the Department has written to a number of other groups on this issue and is currently seeking feedback from the profession before responding to Government.

**Euthanasia and Physician Assisted Suicide Position Statement**

After a comprehensive year-long policy review by the AMA, including a survey of AMA members, the AMA late last year released its updated Position Statement on Euthanasia and Physician Assisted Suicide 2016. It replaces the Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (Amended 2014).

The core message of the statement is that there needs to be much greater investment in quality end of life care, especially national consistent palliative care services. The statement maintains its position that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life.

It stresses that Governments must do all they can to improve end of life care for all Australians by properly resourcing palliative care services and advanced care planning, producing clear legislation to protect doctors in providing good end of life care, and developing enhanced palliative care services to support doctors, nurses, and carers who provide end of life care. This must also be accompanied by a comprehensive education and information campaign to raise community awareness of the care, compassion, and medical and nursing assistance and expertise that is available to assist patients in the final stages of their lives.

The AMA policy also says that if governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:
● all doctors acting within the law;
● vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
● patients and doctors who do not want to participate; and
● the functioning of the health system as a whole.

The position statement is available [here](#).

**Australian National Centre for Disease Control (CDC) Position Statement.**

The AMA has called on the Government to make Australia a world leader in science, medicine, and research by establishing a CDC. We are the only country in the OECD that does not have an established national authority delivering scientific research and leadership in communicable disease control, and we must join other developed nations in playing a global role in combating infectious diseases and other potential threats to the health of its people.

Diseases and health threats do not respect borders. There are emerging problems of controlling communicable diseases within Australia’s borders, and a CDC would provide a national focus on current and emerging communicable disease threats. The prevention of epidemics, pandemics, and other threats, and the capacity to conduct national responses, must be undertaken by an appropriately funded and staffed CDC.

The CDC would deliver effective communication of technical and surveillance information, and work with the States and Territories to manage the allocation of public health workforces and resources to tackle emerging and current threats. It would coordinate Australia’s vital work with other countries to build international public health capacity through expanding and managing communicable disease surveillance, prevention and control, environmental health, and health awareness and promotion.

The position statement is available [here](#).

**Blood Borne Viruses Position Statement**

The AMA released its Blood Borne Viruses Position Statement in January, calling for needle and syringe programs (NSPs) to be introduced in prisons and other custodial settings, to reduce the spread of Blood Borne Viruses (BBVs) including hepatitis B and C, and HIV. Prevalence of BBVs is significantly higher in prisons, and custodial facilities provide a unique opportunity to protect the health of inmates.
BBVs are a major health problem in our prisons, which is no surprise given that many people are in custody for drug-related offences in the first place. All the evidence shows that harm minimisation measures, such as access to condoms and lubricant, regulated needle and syringe programs, and access to disinfectants such as bleach, protects not just those in custody, but prison staff too.

The BBV Statement also calls for greater emphasis on prevention, reliable and affordable screening, immunisation, and treatment, with stronger referral pathways, and greater investment in specialist services. We also called for specific resourcing and management of HLTV-1, a relatively unknown BBV that affects Aboriginal people in central Australia.

The position statement is available [here](https://www.ama.org.au).  

**Firearms Position Statement**

This position statement is an update of the 1996 version. In the 20 years since the National Firearms Agreement was introduced after the Port Arthur massacre, the AMA has continued its call for gun ownership laws to be tightened, and a national, real-time firearms register to be established.

The AMA has always acknowledged that there is a legitimate role for guns in agriculture, regulated sport, and for the military and police, but gun possession in the broader community is a risk to public health. Since Port Arthur, gun deaths in Australia have halved, thanks to the National Firearms Agreement. However, there are still hundreds of thousands, if not millions, of guns held illegally in Australia.

The position statement is available [here](https://www.ama.org.au).  

**General Practice in Primary Health Care Position Statement**

In January the AMA released a new Position Statement on General Practice in Primary Health Care and called on the Government to set a target for funding GP services, to deliver extra funding for general practice research, and to set up a centre of excellence in general practice and primary care research.

GP services account for just 8 per cent of Commonwealth health spending. The AMA is proposing this be lifted to around 10 per cent as part of an effort to re-orientate the health system to focus more on general practice and primary health care, with long-term savings to the health budget anticipated in return.
With only 2 percent of National Health and Medical Research Council (NHRMC) grants directed to supporting primary health care research, including general practice, the AMA also called for a dedicated stream of general practice research funding in the order of 8 per cent of its grants budget.

The position statement is available [here](#).

**Better Access to High Speed Broadband for Rural and Remote Health Care Position Statement**

The AMA released the above position statement in January, warning that health services in rural, regional, and remote Australia could fall even further behind city services, without urgent Government action to ensure all Australians have access to affordable and reliable high speed broadband.

The AMA believes it is essential that rural and remote Australians, who have more difficulty accessing health services close to home, have access to the same standard of health care, including that provided via technology, as those living in major cities.

Access to high speed broadband for medical practices was identified as the top priority for rural GPs, and the second highest for rural doctors in general in an AMA Rural Health Issues Survey conducted last year.

The Position Statement calls on the Government to adopt the recommendations of the 2015 Regional Telecommunications Review, conducted by the Australian Communications and Media Authority, to develop a new Consumer Communication Standard for voice and data, and to establish a Consumer Communication Fund to underwrite investment in loss-making but essential infrastructure and services in regional Australia.

The statement also calls on the Government to:

- Extend the boundaries of the NBN’s fibre cable and fixed wireless footprints, and mobile coverage, wherever possible;
- Begin an incremental process of expanding the terrestrial network to address increased usage in the future;
- Develop measures to prioritise or optimise the broadband capacity available by satellite for hospitals and medical practices, either by exempting or allocating higher data allowance quotas, or by providing a separate data allowance;
- Create universal, unmetered online access to Government, hospital and health services for people in rural and remote areas;
Establish an innovation budget for development of local infrastructure solutions for rural and remote areas; and

Engage with State, Territory, and local government and related stakeholders to co-invest or coordinate planning to achieve the optimum overall infrastructure outcome for their area. This could involve public private partnerships or the leveraging of philanthropic infrastructure funding through, for example, tax concessions.

The position statement is available [here](#).

**National Medical Training Advisory Network**

The AMA has written in strong terms to the new Minister for Health, the Hon Greg Hunt MP, about the work and strategic direction of the NMTAN. While the AMA supports NMTAN, we are very concerned that it has largely failed to deliver promised outcomes in terms of workforce planning and policy advice.

While the AMA is awaiting a formal response from the Minister, we are hopeful that the appointment of a new Chair will give NMTAN much greater direction and pleased to see a more robust agenda for its next meeting.

**Review of Medical Student Places**

The AMA welcomed the announcement by Minister Gillespie in December last year of a review of the distribution of medical school places and ways in which workforce need in regional, rural and remote Australia can best be addressed. Within this announcement was a clear acknowledgement that workforce data does not support the establishment of new medical school places. This is consistent with the policy advice that the AMA has previously provided to Government.

The AMA will contribute to the review, noting that it has the potential to redistribute domestic medical school places among existing schools and throws up the opportunity for the establishment of new medical schools. Our main concern is to see that overall medical student numbers do not increase and that workforce mal-distribution is more adequately addressed.

**National Training Survey**

The AMA has been pursuing a proposal to implement a national training survey for some years. This proposal became one of the recommendations of the Report of the Council of Australian Governments Health Council National Review of Medical Intern Training that was delivered last
We understand that the concept of the NTS has the in-principle support of the Health Workforce Principals Committee and is now with the Australian Health Ministers' Advisory Council for consideration. The AMA welcomes the commitment made last year by the Medical Board of Australia to an NTS and understands that a number of Colleges have indicated their support for the concept.

**General Practice Training**

The AMA welcomed the announcement earlier this year by the Government that the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine will now administer the selection of medical graduates for their training programs.

AMA has consistently pressed the need for greater professional control of GP training, including in relation to selection, since its 2014 GP Training Forum. This was held in response to reforms to GP Training announced in the 2014-15 Federal Budget.

**Macquarie University Medical School**

The AMA and AMA NSW have written to the Assistant Health Minister to express our complete opposition to Macquarie University’s plan to establish a full fee paying medical school. The AMA understands that the Australian Medical Council (AMC) is due to assess a proposal from the University in March/April 2017.

While only limited detail is available, our assessment is that it will do nothing to help address key medical workforce challenges and it will only add to widely acknowledged pressures on the medical training pipeline.

The AMA and AMA NSW have called on the Government to ensure that the review of medical student places that it has established encompasses the Macquarie University proposal and assesses its value in the context of the policy objectives the Government is seeking to achieve.

**AMA 2016 Safe Hours Audit**

During the week 31 October to 6 November 2016, the AMA conducted an on-line audit of the working hours of doctors in training (DiTs) and salaried doctors. The Audit attracted a strong response and the AMA is currently preparing a report outlining the key results.
Health Care Homes

The AMA continues to be represented on Health Care Homes Implementation Advisory Group (HCHIAG) by AMA Vice President, Dr Bartone, as well as on specific working groups sitting beneath the HCHIAG, being the payment mechanism working group and the patient identification working group.

There have been a number of developments since the last CPMC meeting, including an EOI for practices interested in being part of the trial that closed in December last year. We understand this has been oversubscribed, however, the results of the EOI assessment process are yet to be released.

Overall, GPs remain concerned that much of the detail of the HCH remains outstanding and at the lack of new funding to support the trial.

Approved Pathology Collection Centre Rental Arrangements

Last year, the AMA expressed very public concerns about the Government’s election deal with Pathology Australia to control rents paid to general practices and other medical suites by pathology providers for approved pathology collection centres (ACCs).

The Mid Year Economic and Fiscal Outlook released by the Government in December last year confirms that this deal has been put on hold to allow for more consultation. The AMA strongly welcomes this decision, which provides an opportunity to deliver a more balanced approach that genuinely focuses on inappropriate rental arrangements.

After Hours GP services

The AMA made a submission to the Jackson Review of After Hours Primary Care in 2014. One of the issues raised by the AMA in this submission was the role of medical deputising services and concerns that some of these services were not operating in the way that deputising services are intended.

With ongoing concerns about this issue being expressed by members, the AMA President wrote to the Chair of the MBS Review Taskforce in June 2016 seeking that it review the operation of the relevant MBS items numbers to ensure that they are being used as intended. The AMA understands that the MBS working group subsequently formed to oversee this work has completed its review, with their intent being to release a discussion paper for public comment in the coming weeks.
**Doctors’ Health**

The AMA continues to progress the development of a national health program for doctors and medical students in Australia, with funding to support this provided by the Medical Board of Australia. Doctors Health Services Pty Ltd (DrHS) is overseeing this and has finalised funding arrangements for all states and territories.

A national doctors’ health website is now live, which provides information on doctors’ health and links to relevant services. This is located at www.drs4drs.com.au.

**Public Health Advocacy**

Besides a number of position statements outlined in this report, the AMA has been focusing on key public health issues, such as obesity, physical activity, alcohol misuse and Indigenous Health. Tackling obesity and improving participation in physical activity will be part of key session at the 2017 AMA National Conference.

The AMA’s 2016 Report Card on Indigenous Health focused on Rheumatic Heart Disease and made a call for action to prevent new cases of this debilitating, preventable condition among Aboriginal and Torres Strait Islander people. The Report was launched at the Danila Dilba Health Service, Darwin in November 2016.

The AMA continues receive information about the health needs of some refugees, asylum seekers and detainees on Manus Island and Nauru. The AMA forwards any relevant information to Dr John Brayley, Chief Medical Officer/ Surgeon General, Health Services and Policy Division, Department of Immigration and Border Protection as well as IHMS, who also provide health services offshore.
Australian Government Assessment of the Distribution of Medical School Places

The Government is undertaking an assessment of the number and distribution of medical school places in Australia. The assessment is being undertaken jointly by the Departments of Health and Education. The Assistant Minister for Rural Health, Dr David Gillespie in announcing the assessment said it "will be considered within the context of existing workforce modelling and data, two decades of workforce distribution policies, the expansion of higher education places and the Governments priorities to address the maldistribution of medical professionals across regional, rural and remote Australia."

The National Medical Training Advisory Network (NMTAN) will work with the Department of Health on the assessment.

Medical Deans are keen to work with the Government to address the maldistribution of the medical workforce. Medical Deans believes the level of domestic production of medical graduates is appropriate and the current number of medical CSP’s should be maintained. The most immediate challenge in meeting the workforce needs of rural Australia is to ensure the increase in the number of medical graduates translates into doctors in the specialties and locations most needed. The following points are relevant to the assessment:

- The period of training for a medical practitioner is a long one, including entry level training, prevocational training and specialty training. What happens along this pipeline path will influence the ultimate geographical location in which a doctor lives and works.
- Medical school places are only in play for the early part of this journey and can make a useful but limited contribution to addressing workforce needs in isolation.
- There is a substantial body of evidence about the impact of rural origin and or a quality rural training experience on the likelihood of working rurally.
- Rural Clinical Schools have been successful in both providing medical students with exposure to rural practice and improving the clinical infrastructure in rural communities.
- There is now an increased number of medical students from a rural background. However the opportunities are currently not available for these students to stay in regional areas to complete their specialist training.
- The most important current solution is not another new medical school nor a redistribution of medical school places but rather an investment in regional postgraduate training places (particularly in generalist specialties.) This will ensure that medical graduates who wish to pursue a career in regional and rural Australia can do so without having to return to metropolitan areas to undertake the majority of their specialist training.

Leaders in Indigenous Medical Education (LIME) Network Update

The LIME Connection: The Future of Indigenous Health Education: Leadership, Collaboration and Curriculum takes place in Melbourne, 4 – 7 April 2017. This is the seventh biennial LIME Connection and is being co-hosted by Deakin University, Monash University and the University of Melbourne. Further information can be found through the following link:

http://us3.campaign-archive2.com/?u=198604a33aa48629f42c802fb&id=a170bff4bf&e=d8ba159ba7
Independent Health Pricing Authority – Development of a Teaching and Training Classification

IHPA have advised they are developing a teaching and training classification. IHPA have developed, in consultation, a definition which describes teaching and training as:

“The activities provided by or on behalf of a public health service to facilitate the acquisition of knowledge, or development of skills. These activities must be required for an individual to:

- attain the necessary qualifications or recognized professional body registration to practice;
- acquire sufficient clinical competence upon entering the workforce; or
- undertake specialist/advanced practice in Medicine, Dentistry, Nursing, Midwifery or Allied Health.”

A Teaching, Training and Research costing study has been completed and the IHPA Teaching, Training and Research Working Group which includes a range of clinical experts will oversee the development of the classification. Medical Deans are represented on this group.

The development of the Teaching and Training Classification will occur over 2017/18 and IHPA have committed to extensive consultation. Quality clinical training placements are essential to produce competent medical graduates who can practice safely under supervision. The delivery of clinical training is under significant pressure and it will be important that any Teaching and Training classification recognizes the importance of clinical training to the maintenance of a high quality and well trained medical workforce.

Independent Review of Accreditation Systems

Medical Deans continue to engage with the Review of Accreditation Systems under the National Registration and Accreditation Scheme being undertaken by Professor Mike Wood. Public consultation forums will soon be held and Medical Deans awaits the release of the discussion paper later in February.

Medical Deans 2017 Annual Conference

The Medical Deans 2017 Annual Conference is being hosted by the University of Adelaide at the Adelaide Oval Function Centre on the 12/13 October. The conference provides the opportunity to discuss key challenges in medical education and research and a detailed programme will be available closer to the date.

Professor Richard Murray
President (Acting), Medical Deans

Ms Carmel Tebbutt
CEO, Medical Deans
1. Directors and Council

1.1 Meetings of the Australian Medical Council Limited

The Annual General Meeting of the AMC was held in Canberra on Wednesday 30 November 2016. Members were advised via formal notice that the meeting would consider a special resolution to amend the AMC’s Constitution. The amendments to the Constitution ensure AMC processes continue to be relevant, workable and sufficiently flexible to meet practical needs, to focus on the charitable objective of the AMC and to ensure the Constitution remains relevant and appropriate for the business of the AMC including the objects, activities and operations now and into the future. Some significant amendments include:

- Article 2 (Objects) to reflect the wider purpose and range of the activities of the AMC including working internationally with health, accreditation and testing authorities and agencies to bring about improvement in the AMC's commitment to advancing the quality and delivery of medical education and training of health services in Australia and New Zealand;
- Article 4 (membership) has been amended to include an Aboriginal and Torres Strait Islander member and a Māori member;
- Article 8 (Directors) has been amended to increase the term of office for principal office bearers and directors from one year to two years;
- Article 14 provides for the recognition of the Prevocational Standards Accreditation Committee in the Constitution – as a recognised standing committee the chair, Professor Liz Farmer, is ex officio an AMC Director; and
- Article 17 notes the change in name for the Board of Examiners to Assessment Committee.

NOTE: on request from Ms Magarry and Professor Talley, and approval by all members present, a further amendment was made to the Constitution on the day to include the name change from Committee of … to Council of Presidents of Medical Colleges.

The amended Constitution is available on the AMC website at http://www.amc.org.au/files/09952248822aafe7ae06526f15f330189c15c4f3_original.pdf

Following a call for nominations Associate Professor Jill Sewell AM was re-elected as AMC President and Professor David Ellwood was re-elected as AMC Deputy President.

The following people were elected as AMC directors:

- Director Emeritus Professor Napier Thomson AM (re-elected)
- Director Professor Eleanor Milligan (new Director)
- Director Dr Kim Rooney (re-elected)
Dr Greg Kesby completed his term as an AMC Director on 30 November 2016.

The Council also welcomed Professor Geoff McColl as the new Chair of the Medical School Accreditation Committee, Professor Liz Farmer as the Chair of the Prevocational Standards Accreditation Committee and Professor Richard Murry as the nominee of Medical Deans Australia and New Zealand.

The Directors also reappointed Dr Jules Catt, Post-graduate Medical Trainee, for a further two-year term.

The General Meeting of Council in mid-2017 will be held in Darwin with a focus on health and education challenges in regional and remote areas. The Darwin meeting builds on the work of the Council over the last three years to engage with health services, local practitioners, educators and community leaders to share information on current issues in the health and education sectors.

2. National Issues and Initiatives

2.1 National Registration and Accreditation Scheme – Health Ministers’ 2016/17 Review of Accreditation under the Scheme

The Final Report of the Independent Review of the National Registration and Accreditation Scheme, released in August 2015, made 33 recommendations about the Scheme including 7 about accreditation under the Health Practitioner Regulation National Law which includes both accreditation of programs and assessment of overseas trained practitioners. These largely related to the variability of accreditation arrangements across the 14 regulated professions. There were comments about cost, transparency and duplication of existing accreditation arrangements and the overly prescriptive approach in some existing accreditation processes. Ministers expressed concern about these findings, supported the recommendations in principle, and expressed the view that, while the review recommendations would go some way to improve Australia’s accreditation arrangements, more substantive reform of accreditation functions was required to address the issues raised.

The AMC – and all the accreditation councils – publicly indicated their concerns with the accuracy of the cost analysis completed, which for the AMC conflated the AMC expenditure on international medical graduate assessments and medical program accreditations as medical program accreditations.

Ministers asked the Australian Health Ministers’ Advisory Council (AHMAC) to commission further advice and undertake a comprehensive review of accreditation functions.

AHMAC has now announced the appointment of the Independent Reviewer, Professor Michael Woods, Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney and former Commissioner of the Australian Productivity Commission. Mr Peter Carver, formerly of the Victorian Department of Health is working with Professor Woods, together with two other Victorian health staff. The appointment of the reviewer and the terms of reference for the review are addressed in the communique at ATTACHMENT 1.

Professor Woods has begun informal discussions with stakeholders, and more formal state-based discussion for a are planned.

It is proposed that a discussion/consultation paper is available early in 2017, with comments sought by April 2017 and the review finalised by September 2017.

The AMC will be arranging to meet Professor Woods separately, and will continue its significant contribution to the review, through its own submissions about accreditation
for the medical profession, in conjunction through its membership of the Health Professions Accreditation Councils' Forum.

2.2 National Training Survey

In November 2016 the Senate Community Affairs References Committee released its report *Medical complaints process in Australia*. The report contains six recommendations concerning addressing complaints, bullying and harassment in the medical profession. In response to the report, the Medical Board of Australia and the Australian Health Practitioner Regulation Agency indicated that they would be taking the lead in developing and implementing a national, annual survey of trainees which will give trainees a voice, ‘be a safe place for them to provide feedback on their training experience and enable systemic issues such as potential hotspots of bullying and harassment to be identified’. AHPRA and the Board have further indicated they will work with health departments, employers, medical colleges, and the Australian Medical Council to develop the governance and funding arrangements to make this happen the survey happen.

Following this, in December 2016, AMC attended a teleconference facilitated by AHPRA and the Medical Board of Australia with the Australian Government Department of Health and the NSW Ministry of Health to discuss the National Training Survey.

The areas of discussion included:

- The strong support for a standalone national medical training survey and agreement that the survey should include pre-vocational, vocational trainees and supervisors (AHPRA representatives had raised the possibility of adding some questions to the current Health Workforce Survey which is completed at the time of registration/reregistration);
- Consideration of the best time to undertake the survey (there is some support for the survey to be aligned with registration).
- The governance and structure of a survey including how it will be administered and the results managed;
- That a national training survey should replace some of the existing surveys being undertaken;
- The budget submission NSW Health is planning to make to AHMAC for funding to set up a national training survey, with the aim of moving to implementation in 2018.

2.3 AMC launches new edition of the publication: *Good Medical Practice – Professionalism, Ethics and Law*

The AMC President, Associate Professor Jill Sewell AM, launched the 4th edition of the publication at a function in Melbourne on 19 December 2016.

The new edition has been expanded to include the challenges posed by the use of electronic communications, the internet and social media, patient safety, adverse events and open disclosure of adverse events, and end-of-life care. The book provides a single source of information and serves as a reference for doctors in independent clinical practice and as a guide to medical regulators, lawyers, medical practitioners and community members who serve on performance and conduct panels and tribunals. The 4th edition will complement the AMC’s own publications and assist international medical graduates (IMGs) undertaking the AMC examination process for registration in Australia.

Copies of the new publication will be distributed to all specialist colleges.
3. Strategy and Policy

3.1 Specialist Education Accreditation Committee

The AMC Specialist Education Accreditation Committee last met on 18 August 2016 and considered a range of matters as set out below:

3.2 Recognition of medical specialties

Changes were made to the recognition of medical specialties in 2014 such that the Medical Board of Australia has the responsibility for preparing and making a submission to the Ministerial Council for approval of a specialty under section 13 of The Health Practitioner Regulation National Law ('the National Law'). As a consequence, the status of the Australian Medical Council's Recognition of Medical Specialties Advisory Committee (RoMSAC) was reviewed and as part of its Constitutional amendments the Council agreed to remove the Recognition of Medical Specialties Advisory Committee as a standing committee of the AMC from its Constitution. This change took place from the November 2016 meeting of the Council. All former members of the RoMSAC have been informed of the change.

The AMC and the Medical Board of Australia have worked together to develop a process for prospective applicants that meets the requirements of the Ministerial Council. This process will be finalised in the first half of 2017.

4. Accreditation Assessments

Royal College of Pathologists of Australasia (RCPA) 2016 Reaccreditation Assessment

The team will undertake site visits to a range of accredited training sites from 7 to 11 November 2016 and hold meetings with College committees from 14 to 17 November. The preliminary team meeting was held at the College’s office in Sydney on 1 and 2 September 2016.

Upcoming

Royal Australasian College of Dental Surgeons (RACDS) 2017 Reaccreditation Assessment

As a joint AMC and ADC assessment, the AMC and ADC will appoint team co-chairs. Professor David Ellwood (AMC) will co-chair with Associate Professor David Thomson (ADC).

The team will undertake site visits to a range of accredited training sites from 5 to 9 June 2017 and hold meetings with College committees from 14 to 16 June 2017.

Royal Australasian College of Surgeons (RACS) 2017 Reaccreditation Assessment

In 2017, the AMC will undertake a full reaccreditation assessment of the programs of the Royal Australasian College of Surgeons (RACS). The 2017 assessment will include the education and training programs (including continuing professional development programs) leading to the award of Fellowship of the Royal Australasian College of Surgeons. The fields of specialty practice are:

- Cardio-thoracic surgery
- General surgery
- Neurosurgery
- Orthopaedic surgery
- Otolaryngology – head and neck surgery
- Paediatric surgery
- Plastic surgery
- Urology
- Vascular surgery

Professor Christopher Baggoyle AO will Chair the assessment team. The team will undertake site visits to a range of accredited training sites from 27 to 31 March 2017 and hold meetings with the College’s outgoing office bearers and committees from 3 to 5 April 2017. The team will meet the College’s incoming office bearers and remaining committees from 28 to 30 June 2017.

**Australasian College of Dermatologists (ACD) 2017 Reaccreditation Assessment**

In late 2017 the AMC will undertake a reaccreditation assessment of the programs of the Australasian College of Dermatologists (ACD). Associate Professor Jenepher Martin will Chair the assessment team. The team will undertake site visits to a range of accredited training sites from 28 August to 1 September 2017 and hold meetings with the College’s committees from 4 to 7 September 2017.

**Australasian College for Emergency Medicine (ACEM) 2017 Reaccreditation Assessment**

In late 2017 the AMC will undertake a reaccreditation assessment of the programs of the Australasian College for Emergency Medicine (ACEM). The team will undertake site visits to a range of accredited training sites from 13 to 17 November 2017 and hold meetings with the College’s committees from 21 to 24 November 2017. The meetings with the College committees will be held concurrently with ACEM’s 2017 Annual Scientific Meeting being held in Sydney.

**Royal Australian College of General Practitioners 2017 Progress Report with Visit**

In 2013, an AMC team completed a reaccreditation assessment of the College’s pathways to fellowship. Accreditation was granted for six years, until 31 December 2019, subject to satisfactory progress reports and a review visit in 2017. The 2017 review will consider the College’s progress against the accreditation standards and the remaining conditions on accreditation through discussions with College committees, office bearers and staff. Professor John Kolbe will chair the 2017 review team. It is proposed the review visit will take place in August / September 2017.

**Royal Australian and New Zealand College of Ophthalmologists (RANZCO) 2016 Reaccreditation Assessment**

In late 2017, the AMC will undertake a review visit and report on the College’s progress in addressing the 2017 conditions on accreditation.

5. **Workshops**

The AMC will hold a workshop on 21 February 2017 to consider stakeholder feedback (including from trainees, supervisors, health services/jurisdictions, consumers, community groups and Indigenous health organisations) in specialist medical training. The accreditation standards for specialist medical programs require education providers to have mechanisms for engaging internal and external stakeholders in the program outcomes design and evaluation. Feedback to the AMC indicates that a workshop exploring the purpose of, and processes for, stakeholder engagement will assist to enhance these processes, create common understanding, and clarify AMC requirements.
The workshop titled ‘**Engaging stakeholders in delivering high quality medical training and education**’ will consider:

- the purpose of stakeholder engagement in specialist medical training
- AMC accreditation standards and findings concerning stakeholder engagement
- stakeholder engagement and feedback methodologies and procedures
- effective techniques and processes for stakeholder engagement in governance, program development and evaluation, and teaching and training.

The facilitator for the workshop will be Ms Fiona Tito Wheatland BA (Hons) LLB. Ms Tito Wheatland is a health consumer member of the AMC’s Progress Reports Working Party, and a community member of the Board of the Canberra Region Medical Education Council.

Following presentations in the morning the workshop will split into streams to focus on trainee engagement and feedback, and consumer engagement and feedback.

Most colleges are sending representatives to this.
3. Governance Session

3.1 Minutes from 116th meeting plus actions list

For approval

3.2 Executive minutes

For noting

3.3 Chair Report

For noting, and discussion
## BOARD ACTIONS

<table>
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<tr>
<th>Action item</th>
<th>Description</th>
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| 4.1 | Enhance the Revalidation Working Group  
Convene teleconference | AM |
| 4.1 | Alert the Chief Medical Officer to the issue of BBV screening and desire for a separate meeting  
Write to the Prime Minister following the finalisation of the report arising from the Summit | AM- NT |
| 4.2 | Inform Dr Bastian Seidel of the RACGP appointment to the CPMC Executive  
Inform Professor Anthony Lawler of the ACEM and Professor Christopher Baker of the ACD of their appointment to the Executive applicable from 2017 | NT |
| 5.1 | Alert Colleges of the merit in publishing the Indigenous status of their Fellows and trainees as a recommendation arising from the meeting – via College CEOs  
Appoint Professor Ruth Stewart as Chair of the Indigenous sub-committee which will co-Chair the Common Collaborative Forum with AIDA  
Advise AIDA of the appointment  
Provide the necessary background materials to Professor Stewart regarding the project, previous minutes, relevant information | AM |
| 5.2 | Appoint Professor Truskett to the role and advise the SRSA program management | AM |
| 6 | Expand the Revalidation Working Group with the agenda to define what Colleges agree on and what they do not in terms of the EAG report.  
Following this meeting, send a request to the Medical Board to convene a forum in early 2017. (Coordinates with the action item from 4.1) | AM |
| 6.2 | Take the issue of whether to convene a National Workforce Summit in 2017 to the February CPMC meeting | AM |
| 6.3 | Prepare a positive response to the Clinical Pathways correspondence | AM |
| 6.7 | Set up a teleconference with the Executive and Professor Woods, also invite him to the February meeting | AM |
| 7.1 | Accept the proposal from the RACS | AM |
| 7.2 | Circulate the dates for 2017  
Lock in the dates with relevant Colleges  
Seek a venue for the Brisbane meeting (with RACMA President) | AM |
The 116th meeting of the Committee of Presidents of Medical Colleges took place on Thursday 10 November 2016 at the Royal Australia and New Zealand College of Obstetricians and Gynaecologists, 254 Albert Street, East Melbourne.

The meeting commenced at 9am.

1. Welcome and Apologies

Member College Presidents present:

- Professor Nicholas Talley, Chair, Committee of Presidents of Medical Colleges
- Professor Truskett, President the Royal Australasian College of Surgeons
- Dr Catherine Yelland, President Royal Australasian College of Physicians
- Professor Michael Permezel, President, Royal Australia and New Zealand College of Obstetricians and Gynaecologists
- Professor David A Scott, resident Australia and New Zealand College of Anaesthetists
- Dr Adam Castricum, President, Australasian College of Sport and Exercise Physicians
- Dr Simon Judkins, President-elect, Australasian College for Emergency Medicine
- Professor Christopher Baker, President, Australian College of Dermatology
- Dr Ruth Stewart, President, Australian College for Rural and Remote Medicine
- Professor Charlie Corke, President, College of Intensive Care Medicine
- Professor Mark Daniell, President Royal Australia and New Zealand College of Ophthalmologists
- Professor Michael Cleary, President Royal Australasian College of Medical Administrators
- Professor Michael Harrison, President Royal College of Pathologists, Australia
- Dr Bastian Seidel, President, Royal Australian College of General Practitioners

College Chief Executives

- Dr David Hillis, Chief Executive Royal Australasian College of Surgeons
- Dr Karen Owen, Chief Executive Royal Australasian College of medical Administrators
- Dr Peter White, Chief Executive, Australasian College for Emergency Medicine
- Mr Phil Hart, Chief Executive, College of Intensive Care Medicine
- Dr Zena Burgess, Chief Executive, Royal Australian College of General Practitioners
- Mr Tim Willis, Chief Executive, Australian College of Dermatologists
- Ms Alana Killen, Chief Executive, Royal Australia and New Zealand College of Obstetricians and Gynaecologists
- Dr David Andrews, Chief Executive, Royal Australia and New Zealand College of Ophthalmologists
- Ms Kate Simkovic, Australasian College of Sport and Exercise Physicians
- Ms Laina de Winn, representing the Royal Australia and New Zealand College of Radiologists
- Ms Bronwen Ross, representing the Chief Executive, Royal College of Pathologists, Australia
- Ms Elaine X, for the Chief Executive, Royal Australia and New Zealand College of Psychiatrists

Profession Observers

- Professor Jill Sewell, President, Australian Medical Council
- Karin Oldfield, company secretary, Australian Medical Council
- Professor Brendan Murphy, Commonwealth Chief Medical Officer
- Dr Andrew Singer, Principal Medical Adviser, Department of Health
- Dr Joanna Flynn, Chair Medical Board of Australia
- Dr Joanne Katsoris, Executive Officer, Medical Board of Australia
- Dr Kali Hayward, President Australian Indigenous Doctors Association
Committee of Presidents of Medical Colleges

FORUM MINUTES

- Mr Craig Dukes, Chief executive, Australian Indigenous Doctors Association
- Professor Villis Marshall, Chair, Australian Commission on Safety and Quality in Health Care
- Dr Michael Gannon, President The Australian Medical Association
- Ms Anne Trimmer, Secretary-General, Australian Medical Association
- Professor Nicholas Glasgow, President Medical Deans of Australia and New Zealand
- The Hon. Carmel Tebbutt, Chief Executive Medical Deans of Australia and New Zealand
- Professor Richard Tarala, President, Confederation of Postgraduate Medical Education Councils
- Dr Jagdishwar Singh, Chief Executive, Confederation of Postgraduate Medical Education Councils
- Ms Helen Morgan-Bander, Chief Executive, Royal New Zealand College of General Practitioners

**Apologies received**

- Professor Anne Kelso, Chief Executive, National Health & Medical Research Council
- Dr Kym Jenkins President-elect, Royal Australia and New Zealand College of Psychiatrists
- Professor Malcolm Hopwood, President, Royal Australia and New Zealand College of Psychiatrists
- Professor Brad Horsburgh, President, Royal Australia and New Zealand College of Ophthalmologists
- Professor Gregory Slater, President, Royal Australia and New Zealand College of Psychiatrists
- Professor Anthony Lawler, President, Australian College for Emergency Medicine

2.1 CPMC CHAIR REPORT

The meeting commenced at 9am on Thursday 10 November 2016 at the Royal Australasian College of Obstetricians and Gynaecologists as opened by Professor Nicholas Talley, Chair of the Committee of Presidents of Medical Colleges.

Professor Talley reported on the issues common to the membership. Professor Talley provided a brief overview of the National Health Summit on Obesity convened by the CPMC the previous day. He described who was present and that with a focus on determining the evidence, the expert speakers worked with the stakeholders present to establish what works to prevent and treat obesity, and what solutions are necessary from a population health perspective to tackle it. The Summit realised a six point plan, as follows:

1. Support for the recognition of obesity as a chronic disease;
2. Target training of health professionals and provide them with a toolbox;
3. Lead by example – make sure we were looking at issues, and responding;
4. Focus on pre-conceptual care and intervention at that stage;
5. Support a national prevention strategy including health at the enviro planning table, and
6. We gained agreement for a tax on sugar – strong signal to be sent regarding that.

Professor Talley commended the recommendations to all present and suggested that obesity should be considered Australia’s biggest health challenge which all present have the capacity to address.

Professor Talley then advised the Forum of the intention by CPMC, at the Annual General Meeting to be held later that morning of the change of the company name, from Committee, to Council of Presidents of Medical Colleges. Professor Talley thanked all participants for their attendance, input and support throughout the year and wished them happy holidays.
President Jill Sewell represented the AMC, spoke to her report as circulated. Also in attendance was Ms Karin Oldfield, the Company Secretary for the AMC.

Professor Sewell referred to the forthcoming meeting of General Council on 30th Nov, working closely on Indigenous and will pass constitutional change to allow ATSI and Maori on all governance levels. The AMC is funding positions aimed at meeting Closing The Gap process.

Professor Sewell alerted the forum to the announcement made recently by the Australian Health Minister’s Advisory Council of the appointment of the Independent Reviewer, Professor Michael Woods, to lead the review of the National Registration and Accreditation Scheme – Health Ministers’ 2016/17 Review of Accreditation under the Scheme. It was noted that Professor Woods is Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney and former Commissioner of the Australian Productivity Commission. Mr Peter Carver, formerly of the Victorian Department of Health is working with Professor Woods, together with two other Victorian health staff. Professor Sewell advised that Professor Woods has begun informal discussions with stakeholders, and more formal state-based discussion forums are planned. It is understood that a discussion/consultation paper will become available early in 2017, with comments sought by April 2017 and the review finalised by September 2017.

The AMC will be arranging to meet Professor Woods separately, and will continue its contribution to the review, through its own submissions about accreditation for the medical profession, in conjunction through its membership of the Health Professions Accreditation Councils’ Forum.

The AMC reported on the issue of a National Training Survey, and work done by the AMC to canvas support for this development. Professor Sewell advised that in the opinion of the AMC, a National Training Survey has the potential to evaluate and improve the quality of training and through better training, support safe patient care. The experience from the UK, where the General Medical Council runs an annual National Training Survey indicates a survey has the potential to streamline and inform the AMC’s accreditation processes, and the quality assurance processes of other organisations, such as the colleges. Professor Sewell mentioned that since the last meeting, a national workshop on a national training survey had been held on 25 August 2016, co-convened by NSW Health and CPMC. The workshop participants expressed strong support for a national survey, and the AMC is continuing to advocate for roll out of the survey.

An update on the Specialist Education Accreditation Committee was provided with Professor Sewell advising that SEAC considered a range of matters, as follows:

Acupuncture accreditation standards: the AMC, on behalf of the Medical Board of Australia, has been developing standards for the assessment and accreditation of programs of study leading to endorsement of registration of medical practitioners for acupuncture. A reference group is assisting AMC staff to revise the draft accreditation standards and process for accreditation in response to stakeholder feedback received.

Memorandum of Understanding (MOU) with Tertiary Education Quality and Standards Agency (TEQSA) has been signed to share information to support quality assurance and accreditation.
Committee of Presidents of Medical Colleges

FORUM MINUTES

The AMC reported it had a very limited MOU with TEQSA to share information about the Australasian College of Dermatologists, which was seeking registration as a higher education provider with TEQSA. The new MOU allows for sharing of information about providers undergoing accreditation, and where appropriate to work together on an accreditation.

Professor Sewell referred members of the forum to the AMC report which contained an update on the accreditation assessments in terms of completed, underway and forthcoming; including which Colleges had undergone accreditation monitoring for the year.

Professor Sewell advised the forum of the AMCs intention to convene a workshop on stakeholder engagement in early 2017.

Professor Sewell responded to questions in relation to accreditation. Professor Charlie Corke, President, College of Intensive Care Medicine (CICMANZ) enquired about whether there was an evidence-based approach to standards, and how is the AMC ensuring such an approach. In reply, Professor Sewell said the review of standards and new areas are as evidence-based as possible. There was a short discussion concerning the cost-effectiveness of the requirements.

Professor Talley posed a question in relation to whether there is any measurement of the quality of trainees as the standards have changed to which Professor Sewell said it was not a simple process although they could measure some impact, but the AMC is concerned to ensure process leads to better outcomes. Professor Talley thanked Professor Sewell for the AMC report to the forum.

2.3 COMMONWEALTH CHIEF MEDICAL OFFICER

Professor Talley welcomed Professor Brendan Murphy, Australia’s Chief Medical Officer and invited him to deliver a report to the forum.

Professor Murphy referred to the report from the Department of Health as circulated. He advised the forum of his previous role as CEO of Austin Health as a nephrologist and active medical researcher. He informed the forum of the importance of the CPMC and stakeholder forum for his role. He had a strong interest in participating in the CPMC strategic agenda.

The Chief Medical Officer referred to the standing agenda items in the quarterly report as follows:

Specialist Training Program (STP) remains in review phase noting that in August 2016, the Minister for Health approved the extension of the STP and the Emergency Medicine Program (EMP) funding agreements with participating specialist colleges at current levels to cover the 2017 academic year. CMO advised that funding arrangements from 2018 onwards will be determined once the Minister has considered the final report of the department’s review of the STP and EMP initiatives.

- It was noted the Minister has also agreed to the allocation of the first tranche of 50 new rural specialist training places to the 10 colleges participating in the Integrated Rural Training Pathway (IRTP)-STP in 2017.
- The department distributed a draft Findings Report on the review of the STP and EMP to all key stakeholders for comment by 20 September.
- The department is planning to hold some discussions in November 2016 with specialist medical colleges and jurisdictions about possible changes to the proposals included in the draft Findings Report. However Dr Singer advised dates were not finalised but it was the Department’s intention that following consultation, a report will be prepared for the Minister setting out the findings of the review and possible reforms to the program for her consideration. The report is expected to be finalised in 2016.
The National Medical Training Advisory Network (NMTAN) advises Health Ministers on issues relating to planning, distribution and coordination of medical training. Professor Murphy provided an update on the NMTAN referring to the completion of the reports on the psychiatry and anaesthesia workforce have been completed and published on the Department’s website; the continuation of work towards completion of future reports which include emergency medicine and obstetrics and gynaecology.

Professor Murphy informed the forum of the change in Chair of NMTAN from Professor John Horvarth to himself in 2017. He advised the forum of his interest in workforce, and is keenly aware of the issues.

Professor Murphy outlined the New Digital Health Gateway which is currently under development, citing it as a key component of the Australian Government’s response to the Mental Health Commission’s Review ‘Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services’. Specifically, he pointed to the intention of the gateway to optimise use of digital mental health services and technology, and a key part of a stepped care approach helping people get to the right type of service appropriate to their needs. It will provide a multichannel platform (for instance, website, social media, and phone line) that will enable the general community, people with lived experience, carers, digital mental health services, and health professionals to access evidence-based information, advice and digital mental health treatment options (and non-digital options if considered more appropriate to need).

Professor Murphy informed the forum that the gateway is being developed and informed through a range of stakeholder engagement activities including a co-design process, recognising consumers and carers as the experts in their own lives, and therefore gaining a deeper understanding of user needs and features required within the gateway. He noted the existing platform would be decommissioned. He referred attendees to the website: https://www.digitalhealth.gov.au/implementation-resources/national-infrastructure/pcehr-b2b-gateway-services

Professor Murphy updated the forum on the status of the Review of the Medicare Benefits Schedule Taskforce by referring to the impressive extent of engagement by clinicians in the process. Professor Murphy noted there was a lot of potential to streamline the schedule, remove idiosyncrasies and defunct items. He viewed the process as a reform activity which would require strategic interpretation and time to complete.

Professor Murphy advised that the Taskforce has released reports from its first tranche committees for public consultation. In addition MBS Review Taskforce released a report from its Principles and Rules Committee. The second tranche committees are currently working through work plans and will be finalising reporting in the coming months. The third tranche Clinical Committees and Working Groups are currently being established.

Professor Murphy referred to the Pharmacy Trial Program (PTP). He reported the Government has funded $50M through the 6th Community Pharmacy Agreement for the Pharmacy Trial Program, the aim of which is to trial new and expanded community pharmacy programs which seek to improve clinical outcomes for consumers and/or extend the role of pharmacists in the delivery of primary healthcare services through community pharmacy.
Committee of Presidents of Medical Colleges

FORUM MINUTES

The President of the Royal Australian College of General Practitioners, Dr Bastian Seidel asked the CMO why there was $50M for the pharmacy trial as compared to Health Care Homes funding for trials, and did CMO have an opinion on allocation. Professor Murphy responded by indicating that the HCH trial is a start, more investment would have been useful. He suggested goodwill was useful.

The President of the Australian College for Rural and Remote Medicine, Professor Ruth Stewart remarked that more analysis of HCH would have been preferred. She remarked that the burden of disease is leaning towards rural and remote, and the HCH program doesn’t address that, nor does a flat rate. There was general agreement that the evaluation of the trials needed to be transparent.

Professor Murphy referred to the National Cancer Screening Register and the appointment of Telstra Health as the Register provider by the Department of Health following an open tender process. He confirmed that while Health has entered into a Services Agreement with Telstra, the Register will be developed and operated by Telstra Health, a standalone business unit of Telstra. Professor Murphy referred to the Register legislation having received Royal Assent on 20 October 2016. As such the Register is in place, with the aim of providing health professionals, including pathology providers, improved access to their patients’ information. The Register will be integrated with GPs’ desktops, allowing them to identify patients’ screening eligibility and history to support real time clinical decision-making. To support the Register’s development and implementation, consultation has been underway with a broad range of stakeholders. Professor Murphy expected that to continue through to the implementation of the Register in 2017.

The President, Royal College of Pathologists of Australasia, Professor Michael Harrison informed Professor Murphy that RCPA had concerns about the new cervical cancer screening program, that as it is a recall system, there would inevitably be peaks and troughs and the concern was about losing people.

Professor Murphy mentioned the Department had decided to take the lead on Lyme Disease.

The President of the Australia and New Zealand College of Anaesthetists, Professor David A. Scott asked the CMO about his approach to defining chronic disease. Professor Murphy responded by taking the question on notice.

Professor Talley thanked Professor Murphy for his address.

2.4 NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

The report from the National Health and Medical Research Council was tabled and noted. No questions or follow-up action items were requested for the NHMRC.

2.5 MEDICAL BOARD OF AUSTRALIA

The Chair, Dr Joanna Flynn represented the Medical Board and referred to the report as circulated. Also in attendance was Dr Jo Katsoris, Executive Officer.

Dr Flynn reported on the appointment of Professor Michael Woods as the chair of the Independent Review of Accreditation Systems, and referred to the terms of reference as including:

- Cost-effectiveness of the regime for delivering the accreditation functions;
- Governance structures including reporting arrangements;
opportunities for the streamlining of accreditation including consideration of the other educational accreditation processes;
• the extent to which accreditation arrangements support educational innovation, and
• opportunities for increasing consistency and collaboration across professions.

In her engagement with Professor Woods Dr Flynn noted that the *Lost in the Labyrinth* report on the Inquiry into registration processes and support for overseas-trained doctors has re-emerged as a policy issue. Dr Flynn confirmed it remains an active issue for the Board and for specialist Medical Colleges and she suggested that the key would be to ensure transparency in process.

**Revalidation**

Dr Flynn provided an update on the approach being taken by the Board and advised that the Board is currently consulting on options for revalidation. The Board had asked its Expert Advisory Group (EAG), chaired by Professor Liz Farmer, for advice about what it should do to make sure that medical practitioners in Australia maintain and enhance their professional skills and knowledge and remain fit to practise medicine.

Dr Flynn referred to the ‘two by two’ approach as outlined in the interim report as having:
• Two parts: Strengthened CPD + proactive identification and assessment of ‘at-risk’ and poorly performing practitioners.
• Two steps: Engage and collaborate in 2016 + recommend an approach to pilot in 2017.

The core features of the proposed approach are:

• Strengthened CPD: Evidence-based approaches to CPD best drive practice improvement and better patient healthcare outcomes. Strengthened CPD, developed in consultation with the profession and the community, is a recommended pillar for revalidation in Australia.

• Identifying and assessing at-risk and poorly performing practitioners: A small proportion of doctors in all countries are not performing to expected standards at any one time, or over time. Another group of practitioners is at risk of poor performance. Developing accurate and reliable ways to identify practitioners at risk of poor performance and remediating them early is critical, with considerable transformative potential to improve patient safety. It is equally critical to identify, assess and ensure there is effective remediation for practitioners who are already performing poorly.

Dr Flynn thanked the Colleges for the level of representation when they met during the individual discussions. She confirmed that the Board has not decided anything yet and requested more information from the Colleges about what they want from the process, suggesting a consensus view would be helpful. Dr Flynn confirmed that she had received the correspondence from CPMC concerning the interim report. She confirmed that no one has suggested CPD should be taken out.

There was a discussion concerning the removal of Fellowship from the public record, and what currently the law allows the MBA to do. The Board confirmed the Specialist register reflects a qualification the individual was awarded, not whether they are a Fellow of their College.

There was agreement that any approach which protects public safety is supported.
Committee of Presidents of Medical Colleges

FORUM MINUTES

There was a request for a forum to be held to discuss methodology for the profile of the doctors at risk as suggested in the interim report and the Board indicated that they would be happy to facilitate that.

The Chair, Confederation of Postgraduate Medical Education Council Professor Richard Tarala asked about the length of time graduates had to complete internship and the Board informed him that while there are people who start internship but don’t complete it, they do in fact have three years to complete all the terms.

A discussion concerning multi-source feedback occurred in the context of what is recommended by the EAG, and that Colleges could start making changes to CPD requirements as well as re-shaping CPD which Dr Flynn saw as constructive.

A question was taken on notice by Dr Andrew Singer concerning the sharing of workforce data collected by Colleges and AHPRA which may be shared between them for more effective workforce planning. Dr Singer indicated that while it was part of the AIHW workforce survey that was now responsibility of Health through Ms Maureen McCarty’s area.

2.6 AUSTRALIAN INDIGENOUS DOCTORS ASSOCIATION

Dr Kali Hayward, President of the Association addressed the forum noting the paper circulated. Also in attendance was Mr Craig Dukes, AIDA Chief Executive. Dr Hayward spoke about the success of AIDA 2016 in terms of the number of students who attended and now wanting to train in pathways to fellowship. Dr Hayward thanked Professor Truskett, President Australasian College of Surgeons for his support and work during the conference. Dr Hayward noted also in attendance at AIDA 2016 was Professor Talley, CPMC Chair and Ms Angela Magarry, CEO.

Dr Hayward referred to the work being undertaken between AIDA and the NMTAN concerning training data and the desktop exercise concerning that. The aim of the project is to obtain sufficient training data to enable more pathways into fellowship.

Dr Hayward referred to the ongoing policy development to form the common collaborative forum between AIDA, CPMEC, CPMC, and the Deans which would reduce the existing duplication of effort and concentrate the expertise to form a collaborative network across the training pipeline. It was agreed that the submission to fund the collaboration was important and it had been lodged with Federal Health.

A discussion occurred in relation to how to raise the level of Indigenous peoples entering medical training more generally and the merit in targeting Indigenous students at school to encourage them to apply.

Professor Talley thanked Dr Hayward for her report.

2.7 AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

The address from the Commission was provided by Professor Villis Marshall, Chair and he referred to his report previously circulated. Professor Marshall referred to the Implementation of the National Safety and Quality Health Service Standards reporting that in 2016, 891 health service organisations in Australia are scheduled to be assessed to the National Safety and Quality Health Service (NSQHS) Standards.
From January to August 2016, 421 health service organisations had been assessed, of which:

- 188 (45%) were assessed to all 10 NSQHS Standards
- 211 (50%) were assessed to Standards 1 to 3
- 22 (5%) new health service organisations were established and undertook an interim assessment
- 74% of all health service organisations met the core requirements of the NSQHS Standards at initial assessment. For comparison, in 2015, 86% met all the core requirements at initial assessment.

Professor Marshall then provided an update on version 2 of the NSQHS Standards, with consultation has been completed and the number of standards in the final draft version 2 has been reduced from ten to eight and the number of actions have been reduced from 256 to 148.

The eight standards in version 2 of the NSQHS Standards are:

- Clinical Governance for Health Service Organisations Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-Associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard

Professor Marshall reported that three Standards from version 1 are no longer separate standards. Key actions from the Patient Identification and Procedure Matching, Preventing and Managing Pressure Injuries and Preventing Fall and Harm from Falls Standards have been incorporated into the eight standards that make up version 2. One new standard has been added: Comprehensive Care.

The process will also update the evidence base, broaden the language, identify who is responsible for who is in charge of the standards, and provide for better navigation.

Professor Marshall provided an update on the Australian atlases of healthcare variation in particular the development of the second Atlas

The second Australian atlas of healthcare variation is in development and will be published in early 2017. The second Atlas is part of a program of work to map geographical variation in healthcare use across Australia, identify variation that may be unwarranted and recommend actions to reduce unwarranted variation. The second Atlas will focus on acute hospital services and will include 22 items from the following clinical areas:

- potentially preventable hospitalisations
- maternity and women’s health
- surgery
- cardiovascular conditions; and
- intensive care

Variation for each item will be presented in maps and figures, and data analysis will show variation by socioeconomic disadvantage and remoteness. New for the Atlas, analysis by Aboriginal and Torres Strait Islander status and public/private patient classification will be presented where possible.
Committee of Presidents of Medical Colleges
FORUM MINUTES

Analysis and commentary for each data item is currently being developed in collaboration with topic expert groups from the five clinical areas. As for the first Atlas, development of the second Atlas is being guided by a Jurisdictional Advisory Group and an Atlas Advisory Group. The Atlas Advisory Group is chaired by Professor Anne Duggan and has representation from a number of clinical colleges.

Professor Marshall provided an update on the Commission’s Collaboration with Independent Hospital Pricing Authority referring to the August 2016 Ministerial direction to the Independent Hospital Pricing Authority (IHPA) about the performance of its functions under section 226 of the National Health Reform Act 2011.

Under the direction, IHPA must advise the Commonwealth, states and territories (the Parties) on an option or options for:

a) “a comprehensive and risk-adjusted model to determine how funding and pricing can be used to improve patient outcomes and reduce the amount the Commonwealth pays for sentinel events, and a set of preventable hospital acquired conditions, defined by the Australian Commission on Safety and Quality in Health Care and agreed by the Parties, that occur in public hospitals; and

b) a comprehensive and risk-adjusted strategy and funding model to reduce avoidable readmissions to hospital that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for an agreed set of conditions and the circumstances in which they occur.”

The Commission is currently leading the following aspects of this work:

i. hospital acquired complications (HACs) list curation, clinical engagement, supporting resources and tools

ii. readmissions – data analysis, providing advice on clinical safety and quality aspects

iii. sentinel events – review of current sentinel events list

iv. clinical considerations around risk-adjustment

Professor Talley thanked Professor Marshall for his address to the forum.

2.8 AUSTRALIAN MEDICAL ASSOCIATION

The President of the AMA Dr Michael Gannon addressed the forum. Also in attendance was Ms Anne Trimmer, Secretary-General of the AMA.

Dr Gannon referred to the report as circulated. He spoke to only some of the issues outlined in their report. Firstly, the AMA 2016 Safe Hours Audit was aimed at ensuring a safe working environment – safe hours leads to safer patient care – and it was not restrictive.

The AMA President reported the regular engagement with the Medical Board concerning Revalidation. Dr Gannon indicated the AMA was satisfied with enhanced CPD and they support it, however are concerned about the modelling of at-risk practitioners, and at the broad nature of the categories. The AMA President affirmed the professional development system is not faulty and they would argue for minimum change and no new layers of bureaucracy.

The Medicare Rebate Freeze remains a key advocacy point for the AMA, with Dr Gannon having met with Health Minister to discuss this because of the significant implications for patient access to care.

The AMA President provided an update on their position in relation to Health Care Homes and trial of the health care home concept, linked to the voluntary registration of patients with complex and chronic disease, built around general practice.
Committee of Presidents of Medical Colleges

FORUM MINUTES

The ten Primary Health Network regions where the initial trial, involving 200 practices, will take place is both unrealistic in timelines and funding. Lack of new funding to support the trial remains a critical issue in so far as GPs will be asked to do more work with no extra funding support.

On the policy reform of Private Health, the AMA President reported it was represented on the Ministerial Advisory Committee which has broad terms of reference to review aspects of private health including closer examination of PHI product design with simplified consumer products; standard product categories; the role of exclusions and restrictions; appropriate excess levels; and the scope of services covered by PHI. The group will also look at consumer information; premium setting; second tier default benefits; risk equalization; single billing; lifetime health cover; and providing better value for money.

Dr Gannon discussed the pathology rents in the context of criticism of government for not identifying unreasonable rents. He referred to the opportunities which will exist with the reform to health records and supported the RCPA on the registries and concerns about creating peaks and troughs in recall system.

Dr Gannon mentioned there had been feedback from the Doctors-in-Training Committee concerning the somewhat glacial pace of the NMTAN deliberations and inadequacy of the pipeline. There was a discussion concerning the need for proper strategic planning on future health workforce requirements. There was a short commentary provided in relation to the cost of training and education and exams.

Dr Gannon took questions from the floor. On the issue of how to maintain the value proposition of PHI, he questioned why there was constantly an increase by approximately six to eight per cent per annum in premiums along with a rising rate of policy exclusions. The discussion resolved to consider the need for government to manage the difference between the mutual funds and the for-profits.

Dr Simon Judkins, President-elect of the Australasian College for Emergency Management asked a question about how to ensure attractive careers, and connectivity with other specialists and services. There was a discussion about workforce planning generally.

Professor Talley thanked Dr Gannon for his address.

2.9 MEDICAL DEANS OF AUSTRALIA AND NEW ZEALAND

Professor Nick Glasgow, Chair of the Medical Deans addressed the forum for the final time as his tenure was to conclude at the completion of the year. Also in attendance was The Hon. Carmel Tebbutt, Chief Executive, MDANZ.

Professor Glasgow responded to questions in relation to the report previously circulated. He mentioned the LIME Network prize awarded in Barcelona, the successful recent Annual conference, and was congratulated on his tenure as Chair of the Deans.

On the issue of whether there would be any more medical schools, Professor Glasgow indicated that while there is no need for any more schools, he cited the political reality of medical education. The conversation was surrounding the developments by Macquarie University in that space.

A question on rural health to ameliorate the geographic maldistribution was posed by the President, Royal Australia and New Zealand College of Obstetricians and Gynaecologists, Professor Michael Permezel.
Committee of Presidents of Medical Colleges

FORUM MINUTES

Specifically, whether there is merit in the Commonwealth obligating medical schools to increase from twenty-seven per cent the number of persons from a rural and regional background to forty per cent to increase capacity in these areas. The Minister has identified a stretch target of thirty per cent. Prof Glasgow said the issue was complex.

2.10 CONFEDERATION OF POSTGRADUATE MEDICAL EDUCATION COUNCILS

Professor Richard Tarala the Chair of the CPMEC addressed the forum. Also in attendance was Dr Jagadishwa Singh, Chief Executive.

Professor Tarala updated the forum on the 2016 Prevocational Medical Education Forum which was hosted in Hobart from 6-9 November 2016, noting the merging of old with new innovations in medical education; wellbeing of trainees and their supervisors; building supervisory capacity; and enhancing career planning initiatives for junior doctors.

Professor Tarala noted that since 2010, prevocational doctors through their state and territory Junior Medical Officers’ Forums have annually released a set of agreed resolutions that capture their key concerns especially as they pertain to education and training matters. The draft resolutions relate to possible roles that Colleges can play such as unaccredited service registrar positions; greater transparency on the development of task substitution roles; strategies for dealing with workplace bullying and harassment; and greater transparency in career planning information. In relation to the latter, Professor Tarala indicated that information on competition and completion ratios is something that is in the bailiwick of Colleges.

On the issue of the Review of Medical Intern Training Professor Tarala reported that CPMEC continues to provide inputs to the two recommendations that are being progressed by the Health Workforce Principal Committee (HWPC) – Work Readiness of Interns and the National Training Survey. The workshop by CPMC and HWPC in relation to this matter was noted however no progress on the recommendation to develop a two-year Australian curriculum for prevocational doctors in a national process that would build on experiences of their work undertaken to establish the Australian Curriculum Framework for Junior Doctors.

Professor Talley thanked Professor Tarala for his report.

Professor Talley concluded the Morning Forum and invited all participants to Morning Tea at 11am.
1st Meeting of the Council of Presidents of Medical Colleges held at the Royal Australia and New Zealand College of Obstetricians and Gynaecologists, 254 Albert Street, East Melbourne on 10 November 2016.

Member College Presidents present:

- Professor Nicholas Talley, Chair, Committee of Presidents of Medical Colleges
- Professor Truskett, President the Royal Australasian College of Surgeons
- Dr Catherine Yelland, President Royal Australasian College of Physicians
- Professor Michael Permezel, President, Royal Australia and New Zealand College of Obstetricians and Gynaecologists
- Professor David A Scott, resident Australia and New Zealand College of Anaesthetists
- Dr Adam Castricum, President, Australasian College of Sport and Exercise Physicians
- Dr Simon Judkins, President-elect, Australasian College for Emergency Medicine
- Professor Christopher Baker, President, Australian College of Dermatology
- Dr Ruth Stewart, President, Australian College for Rural and Remote Medicine
- Professor Charlie Corke, President, College of Intensive Care Medicine
- Professor Mark Daniell, President Royal Australia and New Zealand College of Ophthalmologists
- Professor Michael Cleary, President Royal Australasian College of Medical Administrators
- Professor Michael Harrison, President Royal College of Pathologists, Australia
- Dr Bastian Seidel, President, Royal Australian College of General Practitioners
- Company Secretary Ms Angela Magarry, CEO

College Chief Executives

- Associate Professor David Hillis, Chief Executive Royal Australasian College of Surgeons
- Dr Karen Owen, Chief Executive Royal Australasian College of medical Administrators
- Dr Peter White, Chief Executive, Australasian College for Emergency Medicine
- Mr Phil Hart, Chief Executive, College of Intensive Care Medicine
- Dr Zena Burgess, Chief Executive, Royal Australian College of General Practitioners
- Mr Tim Willis, Chief Executive, Australian College of Dermatologists
- Ms Alana Killen, Chief Executive, Royal Australia and New Zealand College of Obstetricians and Gynaecologists
- Dr David Andrews, Chief Executive, Royal Australia and New Zealand College of Ophthalmologists
- Ms Kate Simkovic, Australasian College of Sport and Exercise Physicians
- Ms Laina de Winn, representing the Royal Australia and New Zealand College of Radiologists
- Ms Bronwen Ross, representing the Chief Executive, Royal College of Pathologists, Australia
- Ms Elaine for the Chief Executive, Royal Australia and New Zealand College of Psychiatrists

Apologies received

- Dr Kym Jenkins President-elect, Royal Australia and New Zealand College of Psychiatrists
- Professor Malcolm Hopwood, President, Royal Australia and New Zealand College of Psychiatrists
- Professor Brad Horsburgh, President, Royal Australia and New Zealand College of Ophthalmologists
- Professor Gregory Slater, President, Royal Australia and New Zealand College of Psychiatrists
- Professor Anthony Lawler, President, Australian College for Emergency Medicine
Opening of the Meeting

Professor opened the meeting by noting that at the conclusion of the 116th meeting of the Committee of Presidents of Medical Colleges held at the Royal Australia and New Zealand College of Obstetricians and Gynaecologists, the company convened its Annual General Meeting and after the vote to adopt a change of name, from Committee to Council of presidents of Medical Colleges, the Board convened the first meeting of the Council at 12:15 pm on the same day.

Meeting papers were coordinated and collated by secretariat, notations made for all Profession Observer papers to inform the Board of the issues and these as well as Board-in-confidence papers were provided to the company directors via secure hyperlink accessible from the CPMC website.

3.1 A Presentation from Dr Jennifer Alexander – Doctors’ Health Services Pty Ltd

Dr Alexander was invited by the Board to present on the expanded doctors’ health services which are now available to doctors and medical students in most states and territories, through the Medical Board’s partnership with the Australian Medical Association (AMA). The AMA administers the health programs at arms’ length from the Board and AHPRA, through the AMA’s subsidiary company, Doctors’ Health Services Pty Ltd (DrHS).

Dr Alexander informed the Board of the background rationale to the establishment of the Doctors’ Health Service including Victoria and Tasmania having joined the national network in July this year with services in these states provided through the Victorian Doctors’ Health Program (VDHP). In addition, expanded services have commenced for Queensland, New South Wales, South Australia, the Australian Capital Territory, and the Northern Territory earlier this year. Arrangements for services in Western Australia are being finalised.

Dr Alexander informed the Board that the services are nationally consistent and available to doctors and medical students across all states and territories. The scope of services provided around the country is comprehensive and includes:

• confidential health-related triage;
• advice and referral services;
• follow-up services for medical practitioners and medical students who need it, including support and advocacy in returning to work;
• education, awareness-raising and advice about health issues for medical practitioners and medical students;
• training to support doctors to treat other doctors, and
• facilitation of support groups for medical practitioners and students with significant health problems.

Dr Alexander provided pre-reading material including articles which supported the presentation.

Professor Talley thanked Dr Alexander for her presentation.

3.2 Dr Monica Trujillo representing the Australian Digital Health Agency

Dr Monica Trujillo, Executive Manager, Clinical and Consumer Engagement and Clinical Governance presented to the Board on the establishment of the Australian Digital Health Agency. The agency was established on 1 July this year, an amalgamation of the National eHealth Transition Authority and parts of the Department of Health’s eHealth Branch. Dr Trujillo indicated that one of their core roles is to work collaboratively with the public, clinicians, clinical representative groups, consumer advocacy organisations, researcher, industry and entrepreneurs to identify how Australia can best use data and technology to support the modernisation of health care.
Dr Trujillo informed the Board that the Agency has a whole-of-system, integrated and strategic approach to digital health services, a focus on clinical quality and safety, and real engagement and collaboration with consumers, healthcare providers, governments and industry. The Agency is also now accountable for all digital health activities nationally.

By way of background, in her presentation, Dr Trujillo advised of the Intergovernmental Agreement on National Digital Health, which describes the Commonwealth and State and Territory governments’ agreement to the establishment and on-going financial support for the operations of the Agency, which was approved by the COAG Health Council on 8 April 2016. The Agency is leading the next stages of consultation to finalise the National Digital Health Strategy – setting out shared vision for digital health innovation to drive better healthcare delivery and outcomes over the next three years. Dr Trujillo advised of the Agency’s intention to conduct the engagement and consultation process with a completion date no later than end of January 2017. In the short to medium term, priorities for the Agency include enabling secure point to point messaging between all healthcare providers, increasing use of My Health Record in public and private hospitals, and upload of pathology and diagnostic imaging reports for patients to their record.

The Agency will also be involved closely with the trial and implementation of Health Care Homes – a crucial element in the Government’s reforms to primary health care.

Dr Trujillo advised of the governance arrangements with the Agency Board membership comprising a broad range of skills reflecting the health community. As previously announced the Commonwealth Health Minister appointed the Agency’s Board Chair and members on 20 April 2016 after agreement from State and Territory Health Ministers and the Federal Cabinet. The Minister also announced the appointment of Mr Tim Kelsey as the Chief Executive Officer of the Agency on 1 August 2016.

Professor Talley thanked Dr Trujillo for her presentation and invited her to remain for lunch with College Presidents and the previous speaker, Dr Alexander.

Lunch was provided from 1pm to 1:30pm at the premises.

GOVERNANCE SESSION
Held on Wednesday 9th November 2016 at the RACV City Club

4. Strategic Governance

Members of the Board convened to discuss strategic governance items from 7pm until 9pm.

Apologies for the session were received from Dr Bastian Seidel (RACGP), Professor Michael Permezel (RANZCOG) and Professor David A. Scott (ANZCA).

Present were: Professor Christopher Baker (ACD), Dr Adam Castricum (ACSEP), Dr Simon Judkins representing the ACEM president Professor Tony Lawler, Professor Charlie Corke (CICMANZ), Professor Michael Cleary (RACMA), Professor Michael Harrison (RCPA), Professor Ruth Stewart (ACRM), Professor Mark Daniell (RANZCO President-elect), Professor Philip Truskett (RACS), Dr Catherine Yelland (RACP).

The meeting was chaired by Professor Talley. In attendance was the Company Secretary.
4.1 Chair’s Report

Professor Talley provided an overview of the activity which has taken place since the previous meeting and including that as described in the executive minutes. Professor Talley drew the Directors attention to the recent CPMC advocacy statements – End of Life Care and Hand Hygiene.

On the issue of Revalidation Professor Talley advised of the establishment of a Working Party which had convened and based on the secretariat collated the issues and concerns from around the Colleges, the group had made a submission to the Medical Board and an offer to meet with the Chair, Dr Jo Flynn was made. CPMC had received communication from the Board’s executive Officer and correspondence indicating that she would discuss the CPMC issues and proposed next steps with CPMC during the Morning Forum.

A discussion occurred reflecting the concern Colleges have regarding the legal risk involved in any revalidation process, in particular where poor performance was notified. The connection between notifications, reporting and roles and responsibilities was discussed for raising with Dr Flynn in the Morning Forum. It was decided that by reference from AHPRA it was the role of the Colleges to undertake remediation. The connection with the Medical Defence Organisations and data held by them concerning complaints was noted as useful if the aim of revalidation is safe practice, a safe community, and all stakeholders should be clear on their roles in relation to notifications and reporting. The concept of multisource feedback was discussed. The slow process of the Board was also noted.

The revalidation working group was augmented to include Professor Michael Cleary and Professor Mark Daniell. Ms Magarry to set up a working group teleconference with members to discuss the communication by the Board and set out the concerns and risks for Colleges.

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<th>Action item 4.1</th>
<th>Enhance the Revalidation Working Group</th>
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<td>Convene teleconference</td>
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On the theme of working with the Indigenous medical association, Professor Talley advised Directors that he had with the President of the Australian Indigenous Doctors Association at AIDA 2016 and discussed the major progress which has been occurring across Colleges in relation to supporting and growing the number of indigenous Fellows. The next steps in forming their common Collaborative Agreement Forum were also discussed and it was determined that the CEOs of both organisations would meet. As it is AIDA’s responsibility to then engage with the CPMEC and MDANZ, a report on progress is to be brought forward by the CEO.

Professor Talley advised of having attended RACGP 2016 academic session and conference with fruitful meetings with the new President, and former President Dr Frank Jones concerning RACGP advocacy and engagement.

Professor Talley noted the administrative and governance work in relation to the Renaming of CPMC which he hoped would help position CPMC more effectively within the broader strategic environment and with our colleagues in New Zealand.

Professor Talley provided an overview of the meeting with the Prime Minister who had shown a strong interest in the population health issue and wanted to do something about the rising rate.
Professor Talley also informed the Board of the government relations day locked in for Monday 21 November 2016 in Canberra where the Executive will meet with the Hon. Ken Wyatt, The Hon. Catherine King, Senator Nick Xenophon, Senator Richard Di Natale, and The Hon. Sussan Ley.

Professor Talley updated the Board on the CPMC National Health Summit on Obesity in relation to the successful Summit, the agreement on a 6 point plan and recommendations to government to form a taskforce. A letter to the Prime Minister would be prepared once the report was finalised. The Rural Specialist Funding Agreement was briefly discussed in terms of the governance process.

Professor Talley invited comment and discussion on items in the broader agenda.

Professor Philip Truskett advised the Board of the intention by government to require screening for blood borne viruses and that the RACS had liaised with the government regarding the cost and little benefit of annual testing. It was agreed that because the issue has broader application for all health care professionals, this was an issue worth raising independently of the CPMC Forum with the Chief Medical Officer, Professor Brendan Murphy.

### Actions

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<td>4.1</td>
<td>Alert the Chief Medical Officer to the issue of BBV screening and desire for a separate meeting</td>
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<td>Write to the Prime Minister following the finalisation of the report arising from the Summit</td>
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### 4.2 Minutes of the previous meeting

Minutes of the previous meeting were accepted as a true and accurate record.

### 4.2.1 Minutes of the Executive

Minutes of the Executive were noted.

### 4.2.2 Executive Composition

Professor Talley noted the composition of the Executive, and benefit of having convened the teleconferences in between the quarterly full meetings of the Board. The composition was discussed as worthwhile drawing from the large, medium sized Colleges, and it was decided that following the Annual General Meeting where the new executive would be determined, there would be space for a smaller College to form part of the Executive. Annual rotations and applying form 2017.

The decision was to form an Executive comprising the following Colleges:

- Chair of the Council of Presidents of Medical Colleges
- The Royal Australasian College of Physicians
- The Royal Australasian College of Surgeons
- The Royal Australian College of General Practitioners
- The Australasian College of Dermatologists
- The Australasian College for Emergency Medicine

Thereafter rotate annually through the alphabet.

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<td>4.2</td>
<td>Inform Dr Bastian Seidel, Prof Chris Baker (ACD) and Professor Anthony Lawler of the ACEM of their appointment to the Executive applicable from 2017.</td>
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4.3 CEO’s report

Ms Magarry’s report was tabled for noting, reflecting activity since the meeting held 18 August 2016.

- Preparations for the Annual General Meeting with legal advice to make the necessary changes to support the motion to change the company name from Committee to Council of Presidents of Medical Colleges.
- Coordinating the input from Directors concerning the change to the company name. Some advance preparatory work to anticipate all of the administrative changes which will be necessary ranging from ASIC notification through to banks and insurers, service providers, stakeholders and the Government.
- Attended the Australian Indigenous Doctors Association 2016 congress in Cairns which incorporated meetings with AIDA to progress the Common Collaborative Forum as outlined in item 5.1
- Managed the governance establishment and related issues for the SRSA program which is discussed in further details at item 5.2
- CPMC co-convened with NSW Health as the leading agency for Health Principles Workforce Officials to report through to Australian Health Ministers on the concept of a National Training Survey, which was a key recommendation arising from the COAG Review of Internship. A draft report has been prepared which is discussed at item 6.4
- Convening the CPMC National Health Summit on Obesity which is discussed at item 6.6
- Attended IAMRA 2016 and convened the CPMC Working Group on Revalidation which produced a submission to the Medical Board.
- Prepared and coordinated the meeting with the Prime Minister including all briefings and logistics both to the PMO and the Executive
- Prepared the government relations day for 21 November 2016 in Parliament House featuring a wide range of Parliamentarians.
- Attended the NMTAN, Department of Human Services meetings, launch of the Australian Society for Medical Research launch, ACHS Council meeting, MDANZ, AMC meetings.
- Coordinated the attendances for the CPMC Chair at various College invited events.
- Liaised with the ACT Regional Manager, RACS concerning government relations, and various policy matters. Item 7.2 discusses the intention by PCMC to shift to new premises co-locating with RACS, Canberra.
- Liaison with the new advisers in the various Parliamentary offices.

4.4 CPMC Financial Statements

The financial statements for the period ending 30 September 2016 were lodged with the CPMC Executive and cleared. The company had submitted all required tax payments (BAS and IAS) and a copy of the recent BAS was supplied to them for information purposes.

Total current assets: $1,061,496.03 reflecting the inclusion of all CPMC operating funds, RHCE surplus and SRSA funds

Total Liabilities: $23,470.96 reflecting operational expenses, provision for leave and LSL

Total Equity: $1,038,025.07

The profit and loss statement showing variance against budget was noted as retaining all income from the SRSA funding agreement. Overspends for the year to-date had occurred in office supplies to support the Obesity Summit, in teleconference expenses, and some travel pre-paid.
CPMC audited statements for the year ending 2015-16 were circulated to Directors at the 18 August meeting and approved, then subsequently signed by 2 Directors and lodged with ASIC.

The Board noted the financial statements.

Item 4.5 Changes in Directors
The Board noted the following changes in Directors since the August meeting.
- Cessation of Director, President, RACGP Dr Frank Jones
- Addition of Dr Bastian Seidel
- Cessation of President, ACRRM, Professor Lucie Walters
- Addition of Professor Ruth Stewart

5. Sub-Committees
At the resumption of the meeting the following members were present:
- Professor Nicholas Talley, Chair, Committee of Presidents of Medical Colleges
- Professor Trusket, President the Royal Australasian College of Surgeons
- Dr Catherine Yelland, President Royal Australasian College of Physicians
- Professor David A Scott, resident Australia and New Zealand College of Anaesthetists
- Dr Adam Castricum, President, Australasian College of Sport and Exercise Physicians
- Dr Simon Judkins, President-elect, Australasian College for Emergency Medicine
- Professor Christopher Baker, President, Australian College of Dermatology
- Dr Ruth Stewart, President, Australian College for Rural and Remote Medicine
- Professor Charlie Corke, President, College of Intensive Care Medicine
- Professor Mark Daniell, President Royal Aust and New Zealand College of Ophthalmologists
- Professor Michael Cleary, President Royal Australasian College of Medical Administrators
- Professor Michael Harrison, President Royal College of Pathologists, Australia
- Dr Bastian Seidel, President, Royal Australian College of General Practitioners
- Company Secretary Ms Angela Magarry, CEO

5.1 Collaboration Forum on Indigenous – update from the AIDA process
A discussion occurred in relation to the Collaboration Forum and status of the AIDA process. It was noted that where there was a Collaboration Agreement in place between AIDA and CPMC, there were similar in existence with the CPMEC and Deans and all had received extensions of time in order to allow for the establishment and funding of the Common Collaboration Forum. A funding submission has been lodged with the Department of Health co-signed by all parties.

Correspondence from the Australasian College for Emergency Medicine was noted with the College having recently published the Indigenous status of their Fellows and specialist trainees (as numbers and percentages) in the report, Specialist Emergency Medicine Workforce and Training Activities 2015 (p.10). The College believes that the collection and publishing of such data is a key component in increasing the Indigenous participation in the emergency medicine workforce and in the whole specialist medical workforce.

Members agreed the merit in publishing the Indigenous status of their Fellows and trainees as a recommendation arising from the meeting.
5.1 Actions item 5.1
Alert Colleges of the merit in publishing the Indigenous status of their Fellows and trainees as a recommendation arising from the meeting – via College CEOs

Appoint Professor Ruth Stewart as Chair of the Indigenous sub-committee which will co-Chair the Common Collaborative Forum with AIDA
Advise AIDA of the appointment
Provide the necessary background materials to Professor Stewart regarding the project, previous minutes, relevant information

AM

5.2 Rural Health: Update on SRSA
The paper supporting this item was noted. Professor Truskett, AM was confirmed as the Chair of the Rural Health Sub-Committee which requires Chairing the Steering Committee for the SRSA program.

Action item 5.2
Appoint Professor Truskett to the role and advise the SRSA program management
AM

6. Revalidation
The issue is a standing item on the Council agenda. This segment of the meeting built upon the discussion at the dinner and with input from having heard from the Medical Board of Australia in the Morning Forum.

It was noted that Professor Richard Doherty was represented on the Medical Board’s Expert Advisory Group. The RACP has lodged a submission and Dr Yelland indicated that the major concern was the management of under-performers, or the five per cent as cited in the Interim Report.

Key issues discussed included under-performers, non-compliance and other performance issues including what the definition is of an under-performer. The importance of maintaining confidentiality provisions, management of the process and clarification of who bears the cost of investigations and any possible remediation process remained unclear. It was agreed that members are best served if remediation is through a College but that an agreed and legally safe pathway was required.

It was agreed that the expanded working group would consider the issues which need discussion with the Board. It should focus on what the political risk is and other legal risk and to set boundaries around the process.

A forum convened by the Board would be called for in early 2017.

A common pathway was necessary where all roles amongst stakeholders were clear. It was agreed that the Colleges role could not be to act as a policing agent on behalf of the Board/AHPRA. It was agreed that CPD was a formative process and not a policing tool and that poorly identifying the poorly performing practitioner was complex. It was acknowledged that the Medical Defence Organisations are aware of the extent of the complaints lodged and managed.
6.2 NMTAN Update

The Board noted the report tabled concerning the status of the NMTAN and in particular the slow process it has taken, however with a change of Chair the process may improve. The issue of whether to convene a National Health Summit on Workforce would be lodged to the February CPMC meeting agenda.

Professor Ruth Stewart noted that any further Summits would need to be considered in terms of the cost, process and administrative support structure currently available and preference to be given to out-sourcing the conference logistics elements.

Action item 6.2
Take the issue of whether to convene a National Workforce Summit in 2017 to the February CPMC meeting

6.3 Clinical Pathways

The Board discussed the request from the Royal Australasian College of Surgeons in relation to the initiative to join with other groups on the idea of a clinical pathway for academics. It was agreed that academia in general was not well support and for the advancement of knowledge this needs addressing. While not discounting the focus on effective clinical training there are other pathways and it was agreed it must start with the trainees. The concept of holding a forum on this matter under the theme, “There are multiple paths to a fulfilling career” was noted.

Action item 6.3
Prepare a positive response to the Clinical Pathways correspondence

6.4 AHMAC Update on the National Training Survey

The Board noted the update on the co-convening of the AHMAC forum on the potential benefits to arise from a National Training Survey.

6.5 Senate Report on Medical Complaints

The Board noted the status of the Senate enquiries generally and in particular the tabling of the Medical Complaints enquiry planned for 16 November, 2016

6.6 National Health Summit on Obesity

Professor Talley updated the Board on the Summit having been held the previous day. He felt there was an appetite for the Colleges to engage with stakeholders and take action in this area as it affects all aspects of medical life and work.
The development of the six point plan was a strong outcome. The follow-up work was noted with the development of the report, consensus statement and issues management through the media.

It was noted that there were three areas Colleges could take immediate action on and the Australasian College of Sport and Exercise Medicine suggested obesity should become part of each College’s Annual Scientific Meeting in the next twelve months. In the medium term, however he questioned what else could be done and while a focus on a sugar tax was a morally appropriate approach, how will all of the strategies identified in the Summit be integrated?

It was agreed that the end game is the prevention of obesity rather than the management of it through mechanisms such as bariatric surgery.

The Board wished to extend their appreciation to Ms Magarry for her effort.

6.7 NRAS

The Board noted the discussion held by the Board, the AMC and others including the paper provided and agreed to make an appointment with the new Chair to discuss NRAS Review.

The Board also agreed to invite him to the February meeting of CPMC.

<table>
<thead>
<tr>
<th>Action item 6.7</th>
<th>Set up a teleconference with the executive and Professor Woods, also invite him to the February meeting</th>
<th>AM</th>
</tr>
</thead>
</table>

7.1 Premises

The Board accepted the proposal for the CPMC premises to shift to new site under sub-lease with the College of Surgeons on a 3 year basis with the option to renew for a further 3 years.

It was also noted that while the new location would be convenient for meetings and forums, the cost of travel and accommodation to Canberra was relatively high in comparison to major cities. The benefit of advance notice regarding the meeting dates was so that the organisers could lock in the best rate early.

<table>
<thead>
<tr>
<th>Action item 7.1</th>
<th>Accept the proposal from the RACS</th>
<th>AM</th>
</tr>
</thead>
</table>

7.2 Meeting Dates for 2017

The dates as circulated with the papers were noted to require circulating once the date for the February meeting had altered to accommodate the Chair. It was decided to hold the first meeting in Melbourne, second in Canberra, third in Brisbane and final meeting in Sydney.

<table>
<thead>
<tr>
<th>Action Item 7.2</th>
<th>Circulate the dates for 2017 Lock in the dates with relevant Colleges Seek a venue for the Brisbane meeting</th>
<th>AM</th>
</tr>
</thead>
</table>

8 Close

The Board meeting concluded at 2:45pm.
1. **Welcome and Introductions**
The meeting opened at 5pm with Professor Talley welcoming all in attendance noting this was the first meeting for the Presidents from the Australasian College of Dermatologists and Australasian College for Emergency Medicine. Professor Talley noted the apology from Professor Phil Truskett.

2. **CPMC Agenda 16 February meeting**
A general discussion on climate related illness occurred where Dr Bastian Seidel offered to forward data relating to this matter to the group. Professor Lawler forwarded some information also. Professor Talley requested that the issue of environment and health be added to the CPMC agenda for general discussion in his report at item 3.3. The inability of Minister Hunt was noted and in his spot on the agenda Professor Lawler will provide an update on the recent media coverage regarding examinations as discussed at item 8, other business. With reference to the need for a strategic planning discussion and other items on the agenda, the CPMC agenda for 16 February 2017 was approved for immediate dispatch.

3. **Political engagement – new Health Minister and re-shuffle**
The interaction which has occurred between members of CPMC and the new Health Minister was noted. A discussion occurred with reference to the briefing note to support the Minister’s meeting with the College Presidents where the following issues should be added:

- Concern regarding the focus on the US health care system where Minister has referred to it as a possible model for Australia particularly where corporates can free up resources for other areas. It was decided that the note to the Minister should point to the facts in relation to the US health system and warn against it as a model but rather retaining Australia’s and improving it.
- National Health Summit on Obesity and the forthcoming article in the Medical Journal of Australia which refers to the Summit and its recommendations particularly the six point plan. It was decided secretariat should alert the Health Minister of the forthcoming article and attach the relevant CPMC detail.
- Given the remit for CPMC is training and development of a suitably qualified and skilled medical specialist workforce, the Minister should be advised of the need to enhance capacity to train in the private sector.
- It was agreed a focus on public health and prevention is important as is dementia research and reducing smoking rates in the Australian population. On the matter of drug threats, the impact of alcohol on public hospital emergency departments needs flagging in context of support for reducing the extent of ICE in rural and regional communities.
- It was agreed that Choosing Wisely needed to be added in terms of the effort being made by the sector to reduce waste in all aspects of health care.
- Ms Magarry to circulate the article by Rohan Mead on possible solutions for the Minister to look at to reduce inefficiencies and provide for greater transparency.
- A focus on STP is vital to support better planning in the health system.
- A general comment in relation to the absence of the AMA President was noted.
- The current situation in relation to the governance and management of the Confederation of Postgraduate Medical Education Councils (CPMEC) was raised as a matter for further consideration in terms of what entity may provide advice in relation to the postgraduate years and in response to national analytical policy processes currently undertaken by the Health Workforce Principals Committee such as Internship and work readiness. It was decided that Ms Magarry would craft a note to the Chief Medical Officer flagging this as an issue for discussion at the 16 February meeting, and add it to the list to discuss later with the Health Minister.
- Ms Magarry flagged that the Health Minister was keen to meet with all College Presidents but due to the conflict with Parliament he was unable to attend Melbourne and the office was currently exploring a new date for when the meeting can occur.

4. Government relations
The Executive noted the possible dates and closed on Monday 20th or Wednesday 23rd March. Ms Magarry would set up meetings and refer to this matter at the 16 February meeting.

5. Financial Statements
The financial statements for the CPMC were circulated with the agenda reflecting the position of the company at the end of January 2017. Ms Magarry reported the company is solvent. There are three accounts managed, for the general operating account CPMC had managed to run the company as well as undertake the obesity summit while projecting an annual result of $130K surplus which is what the company needs to have in reserves as a minimum. As for the rural health account Ms Magarry reported that while there is $656K in the account, some portion of that must be returned to the Commonwealth to acquit the RHCE fund, leaving the remainder for rural grants to individual medical specialists. Ms Magarry reported the funding round would be released on Monday. Ms Magarry reported that for 2017-18 financial year some changes in the expenses will be necessary to better reflect the travel and expected activities (New Zealand engagement, some indigenous travel, and higher rental of premises etc). While CPMC does receive a charge-back for the work managing the SRSA program there may still be additional expenses associated with the increased activity by the Chair and CEO to engage in Melbourne and Sydney and NZ. Ms Magarry indicated that the draft budget would go to the Executive in April and be discussed for approval with the subscriptions at the May CPMC meeting in Canberra. CPMC Executive approved the accounts to proceed to the CMC meeting 16 February.

6. Premises
Ms Magarry update the Executive on the shift to new premises. The lease has been approved and the move is scheduled to take place in the third week of February. The RACS has already shifted and is undertaking all of the setup work to have them function before CPMC moves in. Ms Magarry advised that she had done a walk around and discussed signage and related matters with the ACT Regional Manager today. The space has sufficient room to convene a full CPMC meeting and the strategic planning meeting would occur there. The IT issues including the telephone were still under discussion but it was assumed that CPMC would need to purchase some equipment to comply with the RACS system. The executive noted this update and had no questions.

7. Constitution
Executive approved the plan to have the Chair-elect convene the Constitutional review.
8. **Other Business**

Executive agreed that a Strategic planning day was required to coincide with the Constitutional review and to occur prior. Ms Magarry will coordinate, noting shaping the forum must include the following:

- That the meeting be structured to include a frank discussion of rules of engagement, conditions of where Council speaks with one voice and where if not united what can be said to reflect that.
- That training, clinical standards, and how humans are treated be included in this discussion;
- The output should be showing what has been agreed upon and why
- That including all Colleges the opportunity to engage in the strategic direction is vital to the sustainability of the company.

Within the above context the agenda would be structured to reflect the purpose of the forum be to interact with the Constitutional review whereby any or all of these guiding principles of the function of CPMC are addressed:

- Action
- Advisory
- Sharing of information

It was decided Ms Magarry would add this to the agenda under strategic College business with a view to securing a date in the near term to convene the forum and feed into the Constitutional review.

An overview of the ACEM recent media experience and background was provided by the President, Professor Lawler. It was agreed that part of the function of CPMC is collegiality and support which was evident in the Executive meeting. Professor Lawler was asked to address the full meeting on 16 February and immediately after the address by AMSA, in the Colleges only session.

The meeting closed at 6pm.
3.4 Chief Executive Officer report

**General comment:** The 10 November 2016 meeting included the Annual General Meeting whereby the change of company name was approved, from Committee to Council of Presidents of Medical Colleges. Much of the activity since that meeting has been focussed on the actions arising from both the AGM and the Board meeting, as outlined in the actions list.

CPMC convened the Executive Meets Parliament meetings the following week in Canberra with meetings organised with government, shadow and cross-benchers.

The change of name administration has been completed. A new company logo has been developed to be rolled out over the coming months across all business administration. CPMC has also established a Facebook page to add to the spread of communication vehicles, such as the twitter site.

**Reporting against Performance Plan – for noting**

1. **Strategy**

1.1 Understands the medical, educational, operational, regulatory and political milieu in which CPMC operates

- Develops advocacy, policy and government relations (APGR) plan
- Develops and conducts a government relations day in 2013 building upon regular CPMC meetings.

**Status**

- Plan adopted in 2013 with amendments in accordance with strategy planning day 2016 and subsequent initiation of the CPMC Executive.
- Meetings sought, coordinated and briefings developed for Government Relations Days.
- CEO CPMC holds unrestricted Parliamentary Pass.
- A successful Exec Meets Parliament occurred in late November 2016 with meetings held with new political contacts in the Ministry and back bench plus Independents and Greens.
- Following the resignation of The Hon. Sussan Ley as Federal Health Minister, CPMC Chair forwarded correspondence to her electorate office expressing appreciation of her efforts especially in relation to assisting in securing the grant funding program SRSA.
- Correspondence was also forwarded to Senator The Hon. Arthur Sinodinos as acting Health Minister outlining issues for discussion.
- A minor Cabinet reshuffle occurred 18 January 2017 with the appointment of The Hon Gregory Hunt, to the Health portfolio. Correspondence was forwarded to his office and communication held with him about meeting with the Council.
- The Hon. Ken Wyatt was appointed as the Minister for Aged Care and Indigenous Health. Correspondence congratulating him on the elevation was sent by the Chair. A background briefing is at item 4.2 to this set of papers.
- The Parliamentary Sitting Week for 2017 was previously circulated to members and CEOs for their information. There will be an Executive Meets Parliament likely in March.
- The new Minister for Aged Care and Minister for Indigenous is to meet with the Board and College CEOs in Parliament House on 25th May after morning tea. Also for Indigenous Roundtable planned for early March (see Indigenous Health item).
1.2 Develop and lead strategic planning based on this milieu that includes appropriate new or revised initiatives

- Develops revised UNITE and consolidates input for UNITE version2 or other.

**Status**

- UNITE plan internally focussed, new plan external focus as struck May 2014.
- Strategic Plan and Business Plan 2014-17 in place with regular reporting process.
- Engagement with Council of Medical Colleges New Zealand occurred in 2014 and assists with bi-national policy issues.
- Provided an economic and policy overview to support the 2016 strategic planning forum.
- Establishment of CPMC Executive since 2015-16 to enhance profile, with meetings every 6-8 weeks to coordinate action or continue processes in between the quarterly meetings.
- Convened a National Health Summit on Obesity in 2016 which trended top on twitter.
- Size of Executive increased by 2 additional Colleges at the November 2016 meeting.
- CMC attends CMC New Zealand meetings annually – they come to Australia annually.
- CPMC addition of the Australian Medical Students Association to the Professions Forum.

1.3 Build and maintain the necessary infrastructure to facilitate achievement of these strategic goals.

- Reports against the UNITE, APGR and government relations day activities in CEO report to CPMC
- Establishes CPMC Canberra as hub of government relations for CPMC members

**Status**

- Since 2013 the approach has been capacity building the company (infrastructure, financing and risk management) to fully establish the Canberra office.
- Established regular interaction with Departmental officials, senior officials, advisers and peak bodies in Canberra.
- In February 2017 CPMC to shift to new premises with enhanced capability to convene Board and other meetings in the office.

2. **Operations**

2.1 Ensure the smooth operation of the Committee's activities including meetings, representations and the provision of advice to colleges, government, the media and other organisations.

- Key dates and meetings occur with CPMC, government key stakeholders and MPs/Senators, advisers.
- Establishes media/communications platform for CPMC member information and broader stakeholder awareness.
- Establishes contact with health reporters and college newsletters, >3 pieces per annum

**Status**

- Key dates circulated and locked in for the year at the November meeting following AGM.
- New venues sourced for new cities and in liaison with the relevant College President and office, including dinner venues and related logistics.
- Contact established with key health reporters. CPMC Twitter site established and regularly used as a mechanism for communication at events. Facebook page developed.
- Article written for *Croakey* on collaboration on Indigenous with reference to new government priorities (2014)
- National Health Summit on Obesity coordination of media facilitator (ABC News reporter), media support service, TV, radio, twitter, and follow-up interviews with SBS TV, ABC, and local ABC new services.
- Created CPMC News in 2015 and it is released monthly.
2.2 Ensure provision of high quality programs and services that meet the contracts that CPMC has with governments and other organisations, within agreed budgets and timeframes.
- Existing contracts managed to acquittal and final report.
- Develops new contracts or renewal of contracts consistent with strategic plan and within capacity.

Status
- Prior contracts acquitted and new contracts struck (SRSA)
- Qantas travel agreement – links with other companies and provider relations.
- Consideration to be given to alternative additional income streams.

2.3 Lead effective management of CPMC’s financial resources by building and maintaining appropriate budgeting, investing procedures and controls.
- Financial management moves effectively to Canberra with controls in place
- CPMC Budget established in conjunction with accounting and book keeping services to assist in the audit and control.
- Sub-lease at ANZCA ACT Office in place.

Status
- MYOB used to manage funds, budget variance and provide info to the Executive and Board
- Accounting oversight in place via MCS Accounting
- Auditors changed in 2013 and full re-audit undertaken
- Book keeper appointed in 2013 and tax agent service (same person)
- MOU with ANZCA in place and in February CPMC will shift to new premises under RACS

2.4 Ensure that CPMC operates within an appropriate risk environment through diligent monitoring, reporting and management of risks and their mitigation.
- Develop a risk management plan for internal membership information and awareness (e.g. finance and audit controls)
- Ensure insurances in place at correct coverage.
- Ensure that quarterly risk reporting occurs

Status
While working out of the ANZCA office there is a low OH&S risk from working solo in the building but this will change once in the new premises as there will be reception staff, other tenants in the suite and more on site.

In 2013 and Administrative corporate compliance check was undertaken and it is an annual check:
- Compliance check undertaken of ASIC listing and a new corporate key issued.
- Established CPMC registered office in Canberra, changed in 2016 to MCS.
- Compliance check of CPMC service providers, registered ABN/ACN undertaken.
- Insurances reviewed and change of address provided, fees paid.
- WCI coverage for ACT obtained. Ceased NSW coverage.
- Certificates of currency obtained for all insurances.

Risk assessment of administrative compliance maintained at Low Risk

Risk assessment of revised IT, email and website at Low Risk
3. **Relationships**

3.1 Support CPMC by making available all necessary advice, reports and resources required for the prudent governance of CPMC and the promotion of its mission.

- Information and advice made available through Communiqué and establishes newsletter
- Members are governance aware through orientation pack to CPMC
- Prior to the end of 2016 I advised the membership of the completion of a range of actions arising from the 10 November Forum and Board meeting including progressing the change of company name procedures. I also amended the members guide and provided that to all members including newly elected Directors.

**Status**

- Communiques on the CPMC website since August 2013.
- Newsletter developed and released monthly.
- Facebook page: https://www.facebook.com/Council-of-Presidents-of-Medical-Colleges-1747637405475398/?ref=aymt_homepage_panel

3.2 Establish and build productive relationships with member colleges and engage them in the CPMC’s strategic vision

- Identifies 3-5 core issues from each college CEO which builds an issues brief for the APGR agenda.
- Develops submissions to government where appropriate in conjunction with the presidents and CEOs of the member colleges (>3 per year)

**Status**

- Issues development in tandem with Board and CEOs. Issues management is dependent upon the CPMC Chair and particular approach the Board wants to take.
- Submissions drafted on relevant issues ranging from revalidation, tax, regulation, workforce, public health and other Parliamentary enquiries.

3.3 Provide innovative leadership and effective management of CPMC’s staff, where applicable, conforming with all authorised personnel policies, regulations and laws.

- Divided management function of RHCE/SRSA staff with RACP managed effectively through appropriate support and strategic management oversight of the project.

**Status**

- No direct formal reports but the Projects require strategic direction and interaction.
  - RHCE/SRSA management via RACP – undertook National Program Managers role and provided assistance with replacement of project manager.
  - Daily interaction with ANZCA (ACT) Regional Manager and from February 2017 the RACS regional office staff and surrounding tenants in the new building.

3.4 Contribute to the protection and promotion of CPMC and specialist medical colleges as a whole by liaising with and influencing clients, consumers, the media, government and other health-related organisations

- Meet and greet occurs via CPMC meetings for member benefit, same for immediate stakeholders
- Attendance at Departmental senior officials breakfasts, forums, and via ACHSM
- Draft up articles for op-eds, establish Twitter and use it, initiate media contact and interest and drive that through the APGR plan.

**CPMC meeting 16 February 2017**
COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

Status

- Regularly meet up with Secretary Department of Health; FAS, Health Policy and several peak bodies. CPMC is located in an area of Canberra where many peak bodies are located which allows for regular interaction. I also hold Fellowship status with the Australasian College of Health Service Managers and am on Branch Council and am a National Board member which enables additional networking.
- Established contact with Health Ministerial advisers and relevant electorate officials.
- Weekly update on Twitter where appropriate.

3.5 In addition to these accountabilities, the CEO as a range of working relationships, including with CPMC and its sub-committees, specialist medical colleges and their members, direct staff reports, Governments, other health-related or regulatory organisations, the media, patients and the community.

Status

Representational duties attended as follows:

- Australian Medical Council – Progress Reports Working Party meetings on three occasions each year to review College accreditation reports and make recommendations to the SEAC.
- AMC General Council twice per year.
- Professions Reference Group meeting (AHPRA) -PRG meets twice per year. Involves representatives of each of the regulated professions; discusses and provides advice to AHPRA.
- NMTAN representation
- Department of Human Services stakeholder reference group – member
- Board member, Australasian College of Health Services Management, Executive Councillor (ACT)
- Councillor, Australian Council on Healthcare Standards.

CPMC meeting 16 February 2017
3.5 Financial Statements

The financial statements and discussion are provided to each Executive meeting prior to the Board.

CPMC holds the following funds to the end of January 2017:

Operating account: $48K
Maxi account: $173K
Rural grant: $676K

The balance sheet, profit and loss statements show CPMC has gone over budget for variable costs and the Obesity Summit is the main reason for that where secretariat had to pay for travel, accommodation for keynotes and some speakers to ensure we had the line-up of expertise and media support for that event.

CPMC is also funding international travel for the Chair to attend the IMELF Hong Kong meeting in March. CPMC is projecting an end of year position of approximately $130K as budgeted for. This is the minimum in reserves for managing any risk as approved by the Board.

In preparation for the 2017-18 financial year the CPMC budget will be re-cast and presented to the May meeting.

Recommendation: The Board notes the financial statements.
## Balance Sheet

**As of January 2017**

### Assets

#### Current Assets

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<thead>
<tr>
<th>Bank Accounts</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP: Westpac Cheque 42-3262</td>
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<td>COP: Westpac Maxi 42-3588</td>
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<td>RHCE AC 688025</td>
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</table>

**Total Bank Accounts** $899,131.76

<table>
<thead>
<tr>
<th>Other Asset</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Clearing Accounts</td>
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**Total Current Assets** $910,435.41

**Total Assets** $910,435.41

### Liabilities

#### Current Liabilities

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<thead>
<tr>
<th>GST Liabilities</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
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<tr>
<td>GST Paid</td>
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**Total GST Liabilities** -$1,364.01

<table>
<thead>
<tr>
<th>Payroll Liabilities</th>
<th>Amount</th>
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<tbody>
<tr>
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<td>Superannuation Payable</td>
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**Total Payroll Liabilities** -$2,268.09

<table>
<thead>
<tr>
<th>Other Current Liabilities</th>
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<tbody>
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<tr>
<td>Provision for Holiday Pay</td>
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<td>Provision for Long Service Lea</td>
<td>$8,342.23</td>
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</table>

**Total Other Current Liabilities** $33,053.51

**Total Current Liabilities** $29,421.41

**Total Liabilities** $29,421.41

### Net Assets

**Net Assets** $881,014.00

### Equity

<table>
<thead>
<tr>
<th>Retained Earnings</th>
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</tr>
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<tbody>
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<td>Historical Balancing</td>
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**Total Equity** $881,014.00

This report includes Year-End Adjustments.
### Profit & Loss [Budget Analysis]

**January 2017**

<table>
<thead>
<tr>
<th>Selected Period</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td>$0.00</td>
<td>$500.00</td>
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</tr>
<tr>
<td>Project Mgmt from SRSA</td>
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<tr>
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<tr>
<td><strong>Total Income</strong></td>
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<tr>
<td><strong>Gross Profit</strong></td>
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<tr>
<td><strong>Expenses</strong></td>
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<td>Committee of Presidents</td>
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<td>Teleconference Expenses</td>
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</tr>
<tr>
<td>Other Travel Expenses</td>
<td>$38.92</td>
<td>$400.00</td>
<td>-(90.3)%</td>
</tr>
<tr>
<td><strong>Total Travel</strong></td>
<td>$5,106.55</td>
<td>$5,400.00</td>
<td>-(5.4)%</td>
</tr>
<tr>
<td>SRSA Grant Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding and Management Fees</td>
<td>$0.00</td>
<td>$58,314.40</td>
<td>-(100.0)%</td>
</tr>
<tr>
<td>CPMC Project Management Costs</td>
<td>$0.00</td>
<td>$13,750.00</td>
<td>-(100.0)%</td>
</tr>
<tr>
<td><strong>Total Committee of Presidents</strong></td>
<td>$26,217.07</td>
<td>$101,356.10</td>
<td>-(74.1)%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$26,217.07</td>
<td>$101,356.10</td>
<td>-(74.1)%</td>
</tr>
<tr>
<td>Operating Profit</td>
<td>-$25,760.18</td>
<td>-$86,272.77</td>
<td>70.1%</td>
</tr>
<tr>
<td><strong>Total Other Income</strong></td>
<td>$0.00</td>
<td>$0.00</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Total Other Expenses</strong></td>
<td>$0.00</td>
<td>$0.00</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Net Profit/(Loss)</strong></td>
<td>-$25,760.18</td>
<td>-$86,272.77</td>
<td>70.1%</td>
</tr>
</tbody>
</table>
## Profit & Loss [Budget Analysis]

### July 2016 To January 2017

<table>
<thead>
<tr>
<th>Selected Period</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
</table>

### Income

<table>
<thead>
<tr>
<th>Description</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscription fees</td>
<td>$271,550.00</td>
<td>$294,500.00</td>
<td>-$22,950.00</td>
</tr>
<tr>
<td>Other Income</td>
<td>$1,272.00</td>
<td>$1,000.00</td>
<td>$272.00</td>
</tr>
<tr>
<td>Project Mgmt from SRSA</td>
<td>$43,000.00</td>
<td>$27,500.00</td>
<td>$15,500.00</td>
</tr>
<tr>
<td>SRSA Grant Funds</td>
<td>$727,272.73</td>
<td>$727,272.73</td>
<td>$0.00</td>
</tr>
<tr>
<td>Interest Received</td>
<td>$4,175.97</td>
<td>$5,833.35</td>
<td>-$1,657.38</td>
</tr>
</tbody>
</table>

**Total Income** | $1,047,270.70 | $1,056,106.08 | -$8,835.38 | (0.8)% |

### Expenses

<table>
<thead>
<tr>
<th>Description</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee of Presidents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounting fees</td>
<td>$1,270.00</td>
<td>$1,260.00</td>
<td>$10.00</td>
</tr>
<tr>
<td>Administrative Assistance</td>
<td>$23,332.57</td>
<td>$14,000.00</td>
<td>$9,332.57</td>
</tr>
<tr>
<td>ASIC fees</td>
<td>$351.82</td>
<td>$140.00</td>
<td>$211.82</td>
</tr>
<tr>
<td>Audit Fees</td>
<td>$500.00</td>
<td>$500.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Bank fees</td>
<td>$58.70</td>
<td>$145.00</td>
<td>-$86.30</td>
</tr>
<tr>
<td>Computer Expenses</td>
<td>$8.86</td>
<td>$700.00</td>
<td>$631.14</td>
</tr>
<tr>
<td>Conference Fees</td>
<td>$136.09</td>
<td>$0.00</td>
<td>$136.09</td>
</tr>
<tr>
<td>Internet</td>
<td>$136.09</td>
<td>$0.00</td>
<td>$136.09</td>
</tr>
<tr>
<td>Website Platform Design and De</td>
<td>$0.00</td>
<td>$5,000.00</td>
<td>-$5,000.00</td>
</tr>
<tr>
<td>Legal Fees</td>
<td>$1,068.75</td>
<td>$1,260.00</td>
<td>-$191.25</td>
</tr>
<tr>
<td>Licences and fees</td>
<td>$1,427.27</td>
<td>$1,000.00</td>
<td>$427.27</td>
</tr>
<tr>
<td>Meeting Expenses</td>
<td>$6,625.51</td>
<td>$14,000.00</td>
<td>-$7,374.49</td>
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<tr>
<td>Office Supplies</td>
<td>$1,765.16</td>
<td>$291.70</td>
<td>$1,473.46</td>
</tr>
<tr>
<td>Photocopying Expenses</td>
<td>$0.00</td>
<td>$100.00</td>
<td>-$100.00</td>
</tr>
<tr>
<td>Professional Development</td>
<td>$0.00</td>
<td>$2,625.00</td>
<td>-$2,625.00</td>
</tr>
<tr>
<td>Rent</td>
<td>$3,640.18</td>
<td>$7,000.00</td>
<td>-$3,359.82</td>
</tr>
<tr>
<td>Salaries</td>
<td>$138,258.54</td>
<td>$108,255.00</td>
<td>$30,003.54</td>
</tr>
<tr>
<td>Stationery</td>
<td>$147.98</td>
<td>$0.00</td>
<td>$147.98</td>
</tr>
<tr>
<td>Superannuation</td>
<td>$1,028.55</td>
<td>$1,260.00</td>
<td>-$231.45</td>
</tr>
<tr>
<td>Teleconference Expenses</td>
<td>$937.49</td>
<td>$700.00</td>
<td>$237.49</td>
</tr>
<tr>
<td>Telephone</td>
<td>$1,426.29</td>
<td>$420.00</td>
<td>$1,006.29</td>
</tr>
<tr>
<td>Workcover</td>
<td>$1,630.72</td>
<td>$1,608.00</td>
<td>$22.72</td>
</tr>
<tr>
<td>Travel</td>
<td>$40,303.00</td>
<td>$37,800.00</td>
<td>$2,503.00</td>
</tr>
<tr>
<td>Accommodation</td>
<td>$12,829.68</td>
<td>$14,000.00</td>
<td>-$1,170.32</td>
</tr>
<tr>
<td>Airfares</td>
<td>$21,150.68</td>
<td>$14,000.00</td>
<td>$7,150.68</td>
</tr>
<tr>
<td>Parking</td>
<td>$719.10</td>
<td>$3,500.00</td>
<td>-$2,780.90</td>
</tr>
<tr>
<td>Taxis</td>
<td>$3,232.20</td>
<td>$3,500.00</td>
<td>-$267.80</td>
</tr>
<tr>
<td>Other Travel Expenses</td>
<td>$2,371.34</td>
<td>$2,800.00</td>
<td>-$428.66</td>
</tr>
</tbody>
</table>

**Total Travel** | $40,303.00 | $37,800.00 | $2,503.00 | 6.6% |

**SRSA Grant Expenses**

<table>
<thead>
<tr>
<th>Description</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding and Management Fees</td>
<td>$278,660.00</td>
<td>$408,200.80</td>
<td>-$129,540.80</td>
</tr>
<tr>
<td>Website Developer</td>
<td>$4,725.00</td>
<td>$0.00</td>
<td>$4,725.00</td>
</tr>
<tr>
<td>CPMC Project Management Costs</td>
<td>$43,000.00</td>
<td>$27,500.00</td>
<td>$15,500.00</td>
</tr>
</tbody>
</table>

**Total Committee of Presidents** | $564,756.81 | $642,355.50 | -$77,598.69 | (12.1)% |

**Total Expenses** | $564,756.81 | $642,355.50 | -$77,598.69 | (12.1)% |

### Operating Profit

<table>
<thead>
<tr>
<th>Description</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Other Income</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Total Other Expenses</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Net Profit/(Loss)** | $482,513.89 | $413,750.58 | $68,763.31 | 16.6% |
3.6 Election of Council Chair- Elect

The CPMC Constitution sets out the timing for the election and it must be no later than the first meeting of the year (clause 6.1.2)

6. CHAIRPERSON 6.1 Election of Chairperson

6.1.1 The period of office of the Chairperson shall be 2 terms and a Committee member may not serve as Chairperson more than once. For the avoidance of doubt – (a) the Chairperson shall hold office until the second Annual General Meeting after the Chairperson assumes that office; and (b) time in office filling a casual vacancy under clause 6.2 shall not be counted.

6.1.2 In a year in which the Chairperson’s term expires, a general meeting shall be held, no later than the date of the first meeting of the Committee in that year, at which the Members will elect a Chairperson-elect from the Committee members.

Nominations for Chair-elect closed 20 January 2017.

2 nominations for Chair-elect were received into the CPMC Secretariat. A vote will be required.

Usual practice is for this to occur as a secret ballot with members placing first and second preferences against their preferred director and handing that to the CEO who will tally it and provide results to the Chair.

Recommendation: This is a confidential governance matter for resolution by the Board.

<table>
<thead>
<tr>
<th>Nominee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Phil Truskett, RACS</td>
</tr>
<tr>
<td>Dr Bastian Seidel, RACGP</td>
</tr>
</tbody>
</table>
CURRICULUM VITAE

Bastian M. Seidel MBBS, PhD, MACHI, MRCGP, FRACGP

EDUCATION

Undergraduate, postgraduate vocational & academic qualifications
2007: Membership of the Royal College of General Practitioners (MRCGP), United Kingdom
2006: Certificate of Completion of Specialist Training in General Practice (CCST), United Kingdom
2004: PhD in paediatric immunology (summa cum laude), University of Leipzig, Germany
2001: MBBS, University of Leipzig, Germany

Professional qualifications & recognition
2014: Full Membership of the Australasian College of Health Informatics (MACHI)
2007: Fellowship of the Royal Australian College of General Practitioners (FRACGP)
2006: Specialist in General Internal Medicine & General Practice, Germany

EMPLOYMENT HISTORY

Current vocational positions
Since 2013: General Practitioner (partner & clinical director), Huon Valley Health Centre, Tasmania

Academic positions
Since 2015: Clinical Professor, Wicking Dementia Education and Research Centre, University of Tasmania

Professional positions
Since 2016: President, RACGP
Since 2014: Director, National Asthma Council Australia

SELECTED PUBLICATIONS & PROFESSIONAL ADVOCACY

Refereed journal articles

Books

Advocacy, editorials, national media
www.drbastianseidel.net
I am General Surgeon with an interest in Upper GI and HPB surgery at the Prince of Wales Hospital, Sydney where I have been senior staff specialist for over 30 years. I have had a major interest in surgical training at both an undergraduate and postgraduate level. I was the supervisor of General Surgical training for many years at the Prince of Wales Hospital, and a former member of the Board in General Surgery. I am a member of the Court of Examiners of the Royal Australasian College of Surgeons (retired).

Over the past 15 years I have taken an active role in both the College of Surgeons and General Surgeons Australia. I am a past President of General Surgeons Australia, and a College Councillor. I was a former Chairman of the EMST (ATLS) Committee and the Skills Education Committee. I was the Chair of the Board of Surgical Education and Training and immediate past Censor in Chief. I am the current chair of the Training in Professional Skills (TIPS). I am the current RACS College President until My 2017.

My major interest is in the provision of Emergency Surgery to our community in our current clinical environment. There are major advantages that flow from increasing subspecialisation, but equally there are considerable problems that can develop particularly as it relates to Acute Care provision to the community. This is particularly true in regional and remote Australia and New Zealand. These issue need to be addressed at a professional level. As a result I have been an advocate for “Generalism” as it equates to the provision of emergency surgery.

As a result, I have been involved in the design and assessment of models of care to try and address these competing issues. The Prince of Wales was the first hospital in Australia and New Zealand to establish an Acute Surgery Unit in 2005. This model of care is now spreading through Australia and New Zealand.

My other major challenge is the sustainability of surgical services. The key to this is the preservation of professionalism in surgical practice. The provision of patient centred care is the benchmark by which we are all judged as professionals and how we should judge one another. It is education in the non-technical skills of surgery which will strengthen our place in the community. This education is a current focus.

CPMC is in a unique position to channel the combined aspiration of all medical colleges on aspects of education and patient care to strengthen us all in the political arena. I am keen to help facilitate this process.

I have had a growing interest in governance and have completed a Fellowship of the Australian Institute of Company Directors (FAICD).

Honorary Awards:
Fellowship of Association of Surgeons of Great Britain and Ireland, FASGBI (Hon)  
Member of the Order of Australia, AM “For the development and performance of surgery” 
I have also been awarded an FRCSEd (ad hominem), to be conferred in July 2017.
3.7 Governance – Constitutional Review


The following members offered to be on the CPMC Constitutional Review Working Group (WG):

- Professor Ruth Stewart (ACRRM)
- Dr Adam Castricum (ASEM)
- Dr Michael Cleary (RACMA)

There was no firm agreement on the exact composition of the WG but rather, to bring the issue and process to the next Board meeting to establish the WG and confirm membership. It is recommended that given the review will likely result in changes from the 2017 AGM and onward, the working group should be chaired by the in-coming Chair of Council.

Initial legal advice has been obtained to check the availability of Mr Topfer as general counsel to CPMC and what some of the issues may be to frame a review. For example the review may wish to consider addressing the scope of membership and allowing access for other like-minded groups to both increase the span of influence and funding for a sustainable company.

Directors should note that the WG will be supported by the CPMC secretariat (CEO) who will coordinate the communication, maintain the version control, seek and provide legal advice, pay the accounts and set the proposal up for the 2017 AGM.

The Australian Charities and Not-for-Profit Commission (ACNC) has a template Constitution which is recommends is utilised to ensure adherence to the relevant legislation.

Legal advice may be obtained a two ways, for the working group to refer to their own College Counsel to provide initial opinion, and the CPMC legal adviser to review that; or alternatively for the working group to produce a mark-up and have the CPMC counsel review and revise accordingly.

Legal advice is costly but independent advice is critical where governance is concerned so final oversight from Mr Topfer is required. A total budgetary allocation of $10,000 will be provided for in the 2017-18 operating budget pending approval by the Board.

**Recommendation:** The Board discusses the composition of the CPMC Constitutional Review Working Group and agrees to membership and process.
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:** Provide a Morning Forum for discussion with the membership on issues and with external organisations who wish to liaise with the Colleges.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken – reporting status</th>
</tr>
</thead>
</table>
| 1.1 Maintain standing invitation to key health sector leaders and organisations to participate at CPMC meetings | Invitees will include: Secretary Department of Health Representatives of:  
- Australian Medical Council  
- National Health & Medical Research Council  
- Medical Board of Australia  
- Australian Indigenous Doctors’ Association  
- Australian Commission on Safety & Quality in Healthcare  
- Australian Medical Association  
- Medical Deans of Australia and New Zealand  
An may include:  
- Other representatives  
- Private Health organisations  
- Public Health organisations | February 2017: number of organisations now 11 with CMO, AMA and CPMEC and from May there will be 12 with the addition of AMSA.                                                                                                                                 |
| 1.2 CPMC will organise forums on sector issues of interest to members and intercollege discussions | 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 | February 2017: National Health Summit on Obesity HWPC/AHMAC workshop on a National Training Survey Future forums to be determined but to have a national focus for health & wellbeing of all Australians. |
<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken - reporting status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 2: CPMC will consolidate its influence by meeting with sector and political leaders and through representation at other meetings.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Advocate on CPMC issues to political leaders</td>
<td>• Minister for Health to attend one CPMC meeting per annum</td>
<td>February 2017: Health Minister opened Summit Assistant Health Minister to meet with group in Parliament House at May meeting. Invitation extended to acting Health Minister to address February forum (TBC)</td>
</tr>
<tr>
<td></td>
<td>• Chair &amp; CEO to attend Ministerial Roundtable events</td>
<td>Government Relations Days for the executive have been held twice in 2016, plan to achieve similar in 2017. Cabinet re-shuffle will influence process.</td>
</tr>
<tr>
<td></td>
<td>• Chair / Executive to meet with Ministers once every quarter as part of a government relations day with meetings to be including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Minister Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Opposition Health spokesperson</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Education Minister</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Opposition Education/VET</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Foreign Minister</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Others as required</td>
<td></td>
</tr>
<tr>
<td>2.2 Develop and maintain strong relationships with key sector agencies in medicine, and develop new contacts</td>
<td>• Participate in the regular Secretary’s meetings</td>
<td>February 2017: Secretary has stopped convening breakfast meetings. Strategic planning forum held February 2016 to determine extension to 2014-17 plan. Regular meetings with DHS, AHPRA, Dept Health</td>
</tr>
<tr>
<td></td>
<td>• Conducts a strategic planning forum with key senior officials to steer workforce and other medicine issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Departments of Health in the areas of strategic policy, workforce, rural and population health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Colleges CEOS forum &amp; communications</td>
<td></td>
</tr>
</tbody>
</table>
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.

**February 2017:** CPMC holds 3 positions on the NMTAN, is on the DHS stakeholder reference group, has 3 Directorships on the AMC, is represented on the MBS Review Taskforce in several different capacities, and the PHI Review committee.

**Objective 3:** CPMC will respond to sector issues and members’ requests according to CPMC’s goals and resources.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken- reporting status</th>
</tr>
</thead>
<tbody>
<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><strong>February 2017:</strong> CPMC has regular feedback on issues from sector Colleges.</td>
</tr>
</tbody>
</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 | **February 2017:** annual planning has been a feature of the February meetings with this meeting coinciding with the Chair-elect nomination.  
CPMC has increased its performance in submissions in 2016. |
| **3.3 Advocate for College issues within the sector** | • Information provided to stakeholders via the communique after each quarterly meeting.  
• Twitter monitoring to enable topics of interest to be sent to members |  
**February 2017:** Regular newsletters have been well received by sector and are now made publicly available on the CPMC website. |
|---|---|---|
| **3.4 Establish inter-collegiate knowledge through dialogue at CPMC meetings or in separate forums** | • Newsletters  
• College publications  
• CPMC website (load up some data) |  
• Maintenance of strategic issues session at CPMC meetings for Members  
• Establish the specialist trainee inter-collegiate forum  
• Maintain the CPMC strategic liaison lunch |  
| **3.5 Research and forward projects** | • Complete the Indigenous cultural competency curriculum project  
• Compete for special project work to build capabilities |  
Awaiting the formation of the common collaborative forum to determine appropriate approach to the cultural competency curriculum project as it will require adequate and appropriate resourcing to do it. Have competed and won access to federal funding for SRSA program. |
3.8A

STRATEGY PLANNING FORUM

The Council will convene to discuss strategy to develop a revised strategic plan to fit with the Constitutional review.

In shaping the strategic forum the structure needs to reflect a frank discussion of rules of engagement, conditions of where Council speaks with one voice and what issues are not open to Council comment. The output should be showing what has been agreed upon and why. The guiding principles of how CPMC functions will be explored, noting the three commonly associated with Council to-date as ‘advisory’, ‘action’ and ‘sharing of information’.

The forum will provide an opportunity for all Colleges to engage in the strategic direction of Council and to shape the ongoing sustainability of CPMC as a company and peak body.

A date will be secured for the forum to be held in Canberra at the new premises, as early as possible into the year, and prior to the May 25 CPMC meeting.
4.  GUESTS

4.1  President, Australian Medical Students Association (AMSA), Mr Rob Thomas

CPMC has given the AMSA President an opportunity to address the Council membership as well as participate as an observer initially on the Professions Observer Forum at the first meeting of 2017. The CMC New Zealand structure includes representation from medical students and the contribution made by student representation is effective in influencing pipeline training issues.

- Council will note that AMSA is a company limited by guarantee and comprised of an AMSA Board, National Executive and Members of the company. Board members are Directors of AMSA and the members are the AMSA representatives from each medical School.

- Mr Rob Thomas is since 1st January 2017 the executive director and AMSA President.

- AMSA retains the services of one paid employee (Mr Roger Buckley) who manages the corporate functions of AMSA. Mr Thomas is a Brisbane based medical student who has interrupted his studies before final year at the University of Queensland.

AMSA is the peak representative body for the 17,000 Australian medical students. They advocate for students, meet politicians, hold events and focus through think tank scenarios on issues of current importance to medical training. On 20-24 May the AMSA will convene a National Leadership Development Seminar at AMA House, Canberra. AMSA convenor Ms Honor Magon has discussed the structure with CPMC to facilitate the presence of College Presidents on a discussion panel, for the Wednesday 24th May. The aim of the panel is to talk about medical training into specialisation, what issues students may wish to take note of. An invitation out to all Presidents will be sent by AMSA.

CPMC CEO has provided assistance with AMSA on convening a panel of politicians on the Monday and will also attend that day to liaise with students.

Mr Thomas has been fully briefed on CPMC and will provide a short address and take questions.
BRIEFING ON THE FEDERAL HEALTH MINISTER

The Hon. Gregory Hunt, Minister for Health & Sport

As a result of the Cabinet minor re-shuffle, the appointment of The Hon. Greg Hunt to the Health portfolio was made. This is a brief biography for the purposes of updating the Board on the relevant aspects of his career.

Gregory Andrew Hunt is turning 52 and has been a Liberal member of the House of Representatives since 2001, representing the Division of Flinders in Victoria.

Prior to the recent appointment his was Minister for Industry, Innovation and Science and prior Minister for the environment.

Minister Hunt is a lawyer, having served as an associate to the Chief Justice of the Australian Federal Court before taking up a Fulbright scholarship to Yale University where he was awarded a Master of Arts in International Relations. Minister Hunt was senior adviser to Alexander Downer (1994-1998). He has held private sector roles at McKinsey & Company and the World Economic Forum. He comes from a political family with his father having served as a member of the Victorian Legislative Council between 1961 and 1992.

Commentary on Health

His comments so far on health have been in a press conference given shortly after his appointment and subsequent press release which can be found at: http://minister.industry.gov.au/ministers/hunt/media-releases/appointment-minister-health-and-sport

The second is in his Maiden Speech to Parliament in 2001 where he offered his view on the five key social imperatives facing Australia over the next 20 years, one being health care insurance and the benefits it has in freeing up resources for the rest of society.

http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2002-02-18%2F0010%22

Minister Hunt has confirmed his desire to meet with health care professionals as well as those bodies representing them. Members were requested to provide issues into secretariat so that discussion could be effective. A brief was also provided to the Department.

Update 9 February 2017: Minister unable to attend Melbourne meeting due to Parliamentary commitments. The issues brief will form part of the correspondence to the Minister as well as assist in strategic discussion more generally.

Recommendation: Note brief and issues to discuss with Minister for Health.
Issues to discuss with Health Minister Hunt

1. Ensuring the Sustainability of Australia’s health system
   - What is Minister’s vision for Australia’s health system? (indicate concern regarding the commentary on the US style of health care and provide some facts on concerns)
   - What is the status of the COAG National Funding Agreements beyond 2020?
   - What is the status of the national reform process, noting
     - MBS Review
       - CPMC supports MBS review aim of emphasis on greater transparency and efficiency;
       - CPMC does not support the freeze on MBS rebate;
       - Increase access to items which will assist in the management of obesity and chronic disease and examine merit in changing referral rules to allow direct referrals.
       - Private Health Insurance review aim to reduce complexity and improve consumer information about coverage within the private sector is supported.
       - CPMC does not consider the Federal Government’s Healthcare Homes Initiative adequately funded, and will fail. It is not properly structured or financed and will not result in improved health outcomes for those millions of Australians living with chronic and complex conditions.
       - Choosing Wisely is supported with focus on avoiding low value products, services, or tests.
       - Digital Health – support for enhanced communication between providers
       - End of life care – support a national approach through COAG.

2. Ensuring the Sustainability of Australia’s specialist medical workforce
   - Developing a national medical workforce strategy which ensures a balanced doctor workforce that extends out to rural areas and matches community expectations
   - Support the Specialist Training Program with agreements funding three year programs
   - Support for the 3 year, $100M Integrated Regional Training Placement that will ensure a stable rural medical training pipeline into the future (separate to STP) and for it to grow.
   - Support for Colleges in the development and implementation of rural/regional curricula.
   - Support for psychiatrists practising in rural/remote Australia
   - Increase number of trainees with a rural background
   - Promote Indigenous specialist workforce

3. Population Health
   - Develop an overarching National Obesity Reduction Strategy – refer recent MJA article
   - Develop a national public health approach to reducing alcohol consumption to reduce alcohol-related harm.
   - Improve Indigenous health and wellbeing through increased Indigenous specialists
   - Reduce the prevalence of ear disease among ATSI people and identify gaps in services

4. Regulating the Australian Specialist Medical Sector
   - Continue with the current approach to revalidation of doctors by the MBA, which encompasses an enhanced CPD approach by medical colleges coupled with risk assessment to identify poorly performing doctors.
   - Introduce national regulation of healthcare facilities and standards as they relate to all but minor surgical or interventional procedures.
   - Direct the Department to oversee the development of a critical drug list by the TGA and have a coherent strategy for minimising the impact of global or local drug shortages.

CPMC meeting 16 February 2017
1. **Relationship between trainee numbers and ability to guarantee specialist procedural access**
   
   This item relates to the issue of difficulty in training procedural specialists where in certain jurisdictions the public hospital system does not provide enough major procedures to train specialists, yet if Colleges try to reduce numbers of specialty trainees this is perceived by the ACCC as 'anti-competitive.' (Question added to Ministerial section: Will the Health Department support Colleges in matching trainee numbers with procedure numbers, so that we don't have large numbers of trainees with insufficient skills and experience to perform procedures?)

2. **Incentives to encourage specialists to move to rural and provincial regions**
   
   This item relates to what planning has occurred to encourage newly-qualified specialists to leave major centres and move to smaller communities.

3. **The National Maternity Framework**
   


   The view from RANZCOG is that GPs, rural and remote doctors, anaesthetists, paediatricians, obstetricians, and many other medical providers - appear to have been omitted, yet obstetric disasters are among the most expensive and shocking adverse outcomes around. (In a question to the Minister: Will there be Commonwealth leadership to promote collaboration, rather than division?)
5 STRATEGY

5.1 Indigenous Health – Collaborative Forum

Professor Ruth Stewart, President, Australian College for Rural and Remote Medicine has agreed to Chair the CPMC element of the common collaborative forum. A full briefing and background material has been provided to Professor Stewart to assist with the process.

A meeting is scheduled for 16 February between all of the stakeholders involved in the establishment of the Collaborative forum – AIDA, Dean, CPMEC, and CPMC. It will discuss resourcing the forum because the Health Department has declined to fund it but has provided funds to support a few other projects AIDA is to undertake.

Following this meeting, it is anticipated that AIDA will coordinate the first meeting of the collaboration. CPMEC has made the CEO role redundant so in discussion with the office, it appears the President Richard Tarala will assume representational duties covering this matter.

Recommendation: For noting

5.1.2 Ministerial Roundtable

The Hon. Ken Wyatt, Minister for Indigenous Health has proposed convening a Ministerial Roundtable to discuss issues and provide advice in relation to achieving outcomes in his portfolio. Minister is particularly keen to arrive at an agreement to work on the Tier 3 determinants of Indigenous Health. These can be found at: [http://www.healthinfonet.ecu.edu.au/health-facts/health-performance-facts](http://www.healthinfonet.ecu.edu.au/health-facts/health-performance-facts)


The Prime Minister will likely attend for part of the roundtable.

At the time of writing this paper the likely dates are 13th or 16th March in Canberra or Sydney with the matter to be confirmed by the chief of staff and College Presidents invited by the Minister accordingly.
5 STRATEGY

5.2 Rural Health- for noting

Directors will note that the Board confirmed the membership of the *CPMC Rural Health Expert Committee* (the SRSA Sub-Committee) as a requirement of the Commonwealth funding agreement of the Support for Rural Specialists in Australia (SRSA) program.

The SRSA Sub-Committee have met on a monthly basis via teleconference to oversee the strategic management and implementation of the program. Since the Board meeting in November 2016, the committee and PMU have completed the following key activities:

- Sub-committee reviewed and approved the updated SRSA Funding Round 1 process, guidelines, and application forms.
- Application process streamlined by removing Specialist Medical College verification.
- Communication strategy has been developed for the launch of the new Program.
- Evaluation strategy has been reviewed and approved.
- Designed and developed new SRSA logo and program website.

The key activities planned for the next reporting period include: the PMU to open Funding Round 1 and implement the communication plan (Feb to March), establish an Assessment Panel to review and rank applications (early April), and PMU to distribute successful and unsuccessful grant recipient letters (late April).

**SRSA Funding Round 1**

The approved program budget has allocated Funding Round 1 $450,000.00 for rural and remote specialists to apply for Individual Medical Specialist grants to access CPD. Specialist who meet the application criteria can apply for up to $10,000.00 (at $2,000.00 per training day, for a maximum of 5 days).

Successful applicants must be living and working in areas determined by the [ASGC standard for Remoteness Areas](http://ruralspecialist.org.au) from categories RA-2 (inner regional) to RA-5 (very remote). Proposed CPD activities must be undertaken between 17 April 2017 and 28 February 2018. Applications for Funding Round 1 will open 10 February 2017 and close 31 March 2017.

Directors will note that General Practitioners (from ACRRM and RACGP) are ineligible to apply for funding under the SRSA Program, as CPD for these practitioners is funded through other Australian Government programs.

The PMU will engage the Specialist Medical College SRSA liaison officers to assist with the promotion of the program. For complete Funding Round 1 guidelines and application forms go to: [http://ruralspecialist.org.au](http://ruralspecialist.org.au) or email the PMU via admin@ruralspecialist.org.au

**RHCE Stream One program acquittal**

The Department of Health have accepted the final RHCE Stream One audited financial statements which officially close off the previous program. The Department will invoice the CPMC the amount of $145,133.00 (GST Exclusive), which represents the unspent funds at the conclusion of RHCE Stream One.
5 STRATEGY

5.3 Revalidation

CPMC has supported the concept of revalidation as a mechanism which builds upon the existing clinical governance system in Australia. In particular CPMC supports the current approach to revalidation of doctors by the MBA, which encompasses an enhanced CPD approach by medical colleges coupled with risk assessment to identify poorly performing doctors. CPMC does have concern about any mechanism which increases the administrative burden on doctors, or indeed shifts responsibility for regulation onto other parties. CPMC held a national forum on the topic in November 2014 and the report can be found at: http://cpmc.edu.au/wp-content/uploads/2014/01/CPMC_Revalidation_Report_2015.pdf

The release of the report by the Expert Advisory Group can be found at: http://www.medicalboard.gov.au/News/Past-Consultations.aspx to which CPMC attended a consultation forum (notes attached). All of the submissions received into the MBA before the end of December 2016 can be viewed on the above link. It should be noted that some of the comments are from individual practising medical specialists who have questioned how the process should now require they prove their worthiness of registration, and have called for the process to start over and to properly engage doctors. The Council submission is listed in that link FYI.

The focus by the MBA experts is for a process to be put in place which deals with CPD non-compliant doctors and there is a risk Colleges will be required to inform the MBA when their members are non-compliant with CPD. This changes the relationship between Colleges and their members and in fact shifts the responsibility for regulation onto alternative parties. The same goes for hospital administrators having to report to the MBA when doctors have complaints made about them.

A joint forum was held between the Medical Council of New Zealand and the Medical Board of Australia with specialist Colleges on 3 February 2017, which covered a range of issues, as outlined in the attachment A by Dr Yelland.

CPMC has established a Revalidation Working Group but due to conflicting priorities no meeting could be held prior to the end of 2016 and it was decided to hold over commentary and discussion as a standing item on the CPMC agenda for the remainder of 2017 given the MBA process being put in place will likely require full Board attention.

The approach CPMC may wish to take is for a Position Statement to be developed which builds upon previous commentary and sets out the role of Colleges in the relationship with doctor’s regulation.

Recommendation: Board notes the EAG report, and concerns, and discusses the CPMC approach.
Attachment A: Medical Board of Australia and Medical Council of New Zealand

Joint meeting with Specialist Colleges - Melbourne 3.2.17

The meeting was attended by several presidents and CEO’s of the Medical Colleges. Dr Yelland attended on behalf of the CPMC. This is a brief summary of the issues relevant to the CPMC.

Overview of developments in Australia and New Zealand: Current issues (Joanna Flynn)

- Two parts of the Revalidation plan
  1. Strengthening CPD: generally well accepted
  2. Managing Practitioners at risk: more concerns and questions

  Social research has been conducted with 3000 doctors and 100 consumers

  Doctors remain one of the most trusted groups in Australia

  Differences in expectations of consumers and doctors - eg 70% if consumers and 40% of doctors thought there should be regular practice review.

- Review of chaperone arrangements: debate about effectiveness
- International Medical Graduates
- Medical complaints (recent Senate Enquiry)
- Lyme Disease
- Strengthening Code of Conduct in “Good Medical Practice”.
- National Training Survey: MBA will take the lead
- Research into vexatious complaints

Feedback on Consultation on Revalidation (Liz Farmer). Report due June 2017

- 400 attended forums, 100 used discussion forum or survey, 116 written submissions
- mostly positive feedback
- some colleges are developing and expanding peer review activities
- colleges want time, frames and congruence with NZ
- issues about doctors working across 2 scope - eg GP anaesthetists
- need access to data by craft group
- strengthen outcome based activities for non-hospital affiliated doctors - will this need a single independent body for those outside the colleges?
- increase colleges as a “CPD Home”
- still need better understanding of assessment of risk and the roles and responsibilities of colleges.
- Colleges willing and able to assist but concerned about resources.
- Can colleges support local intervention?
- Strengthened CPD will probably not be the whole answer
- Much conversation about remediation and how to manage the doctor who fails to remediate

Australian Medical Council (Ian Frank)

- Indigenous Health Advisory Group: indigenous participation in all committees
- Accreditation standards reviewed and modified in 2016
- New standard on Trainee Well Being
- Assessment of OTD’s
- 2014: process simplified and delegated to colleges
COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

- 2015: primary source verification simplified
- non specialist IMG’s: testing centre in Melbourne: OSCE’s videorecorded to manage appeals.

Recertification/revalidation

Update from New Zealand  (Philip Pigou. CEO, MCNZ)

- current requirements: 50 hours, including 10 hours of peer review and 20 hours of CME, annual audit of medical practice
- at risk group (males, practising for 20-40 years). 3 main categories
  - inadequate or inappropriate therapy
  - missed, incorrect of delayed diagnoses
  - unprofessional practice
- emphasis on individual doctor’s needs - audit of medical practice, feedback from review undertaken by peers, MSF.

Evaluation of Regular Practice Review - RPR. (Joan Crawford, Strategic Programme Manager, MCNZ)

- Started in 2014. 249 doctors completed a survey 2 weeks after RPR
- Portfolio of outcomes - peer observation with a proforma, audit against current standards, survey of practice manager and 20 patients, 360° MSF, log books, MSF etc.
- Before RPR, most were anxious or ambivalent, and thought it would be useless
- After: 71% were positive, 61% found it useful, 59% would recommend it to another doctor
- Valued the opportunity for comparison and ideas for improvement.
- 70% reflected on their practice, 47% changed their practice and 12% intended to change, but 40% did not or did not intend to change practice, 50% intended to adjust PDP and 46% thought it had improved their care.
- 12 months later - 45% had made changes, 55% had not made any changes
- could extend RPR to 3-5 yearly intervals.
- Each college should have an RPR process available for their members
- Major issue is high risk doctor and who takes responsibility. What is a doctor at risk and what is an impaired doctor?

Cultural Competence

- Brief history of NZ relevant to health disparities: land and resource loss, environmental degradation, economic disparity, institutional racism. Health system design, biologic/genetic vulnerability.
- Aim for the same outcome - not the same input (equality vs equity)
- Entry of Maori to medical schools is now at 15% - population parity
- Need to support data collection
- Cultural competence as part of annual appraisal and recertification
- Cultural competence is and AMC/MCNZ standard - is our training attractive to indigenous doctors

Bullying and Harassment

- It is acknowledged there is a problem, work is underway and more is to be done
- Recommendations
- Everyone needs to work together
  - Part of curricula
  - Universities and students
  - Code of Conduct in Hospitals
  - Reporting by Colleges
  - Another enquiry - probably by May
  - Relationships between all the entities
  - How does AHPRA regulate?
  - Is the legislative framework fit for purpose?
- “The system suits the people in the room” (Elizabeth Broderick)
Specialist international medical graduates

Snowball report

1. Performance of specialist colleges in applying standard assessments of IMG’s
2. Concern about standardization, transparency and timeframes
3. MBS/AHPRA Good Practice Guidelines
4. Transparent, accountable, effective, efficient and fair
5. Reasonable fees
6. Restrictions on practice
7. Data collection
8. Development of benchmarks

- But still a perception that the process is not transparent and fair
- Another external consultant review is to be done - probably by end of 2017
- Deed of appointment to colleges to assess SIMG’s - will replace letter of appointment
- Retains Mutual collaboration and consultation
- Compliance with Good Practice Guidelines
- Confidentiality, privacy and access to information
5.4 Senate Community Affairs References Committee

5.4.1 Report from the Senate Community Affairs Medical Complaints Process in Australia

In late 2016 the Senate Community Affairs References Committee released its report into the medical complaints process in Australia and made six recommendations. Two of them directly relate to the specialist Medical Colleges. Each is listed below with discussion following.

Recommendation 1
4.25 The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:
• acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike;
• recognise that working together and addressing these issues in a collaborative way is the only solution; and
• commit to ongoing and sustained action and resources to eliminate these behaviours.

Recommendation 2
4.27 The committee recommends that all universities adopt a curriculum that incorporates compulsory education on bullying and harassment.

Recommendation 3
4.30 The committee recommends that all universities accept responsibility for their students while they are on placement and further adopt a procedure for dealing with complaints of bullying and harassment made by their students while on placement. This procedure should be clearly defined and a written copy provided to students prior to their placement commencing.

Recommendation 4
4.32 The committee recommends that all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students and volunteers.

Recommendation 5
4.35 The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.

Recommendation 6
4.37 The committee recommends that a new inquiry be established with terms of reference to address the following matters:
• the implementation of the current complaints system under the National Law, including role of AHPRA and the National Boards;
• whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;
• the roles of AHPRA, the National Boards and professional organisations – such as the various Colleges – in addressing concerns within the medical profession with the complaints process;
• the adequacy of the relationships between those bodies responsible for handling complaints;
• whether amendments to the National Law in relation to the complaints handling process are required; and
• other improvements that could assist in a fairer, quicker and more effective medical complaints process.
Discussion

Once a committee releases its report it is tabled in the Senate with this one listed as having been tabled on 30 November 2016. Government has acted upon Recommendation 6 with the reference to conduct the enquiry discussed at 5.4.2 below. Senate reports usually contain recommendations which are directed at any relevant bodies but mostly the Federal government. There is a requirement of government to inform the Senate of their response to committee reports within three months of tabling. There is no requirement on individuals or organisations to act upon any Senate Committee of Enquiry recommendation per se and it is unclear what enforcement provisions are applicable, if any.

In the case of the two recommendations directly affecting specialist Medical Colleges, recommendation one could reasonably be expected to have been addressed already by CPMC with the statement on the website at: http://cpmc.edu.au/media-release/cpmc-statement-on-bullying-discrimination-and-sexual-harassment/. This statement refers to the prevalence of bullying and harassment and the benefit of all parties (the medical profession governments, hospitals, specialty colleges and universities) working together and addressing these issues in a collaborative way and committing to ongoing and sustained action and resources to eliminate these behaviours. Board may wish to revise the statement to update it and secretariat will do so and pass through the members out of session if required.

It is recommendation five which requires some consideration with regards to the approach to be taken. The Senate recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.

This recommendation requires discussion amongst the College Presidents from the perspective of what is currently published and in what format (de-identifying members and so forth), what is feasible and practical which will result in meeting the aims of recommendation one, to build ongoing and sustained action to eliminate the behaviour.

The College of Surgeons (RACS) has been most active in this area and in December the Presidents update on progress at: http://www.surgeons.org/news/let’s-operate-with-respect-2016-update/ outlines what processes are underway in twenty areas which may take three years to complete, and other training requirements.

In addressing the recommendation there needs to be consideration of what is currently made public by Medical Colleges and then establish a framework to direct any form of reporting to ensure consistency between Colleges and with any external publications.

**Recommendation:** Board notes the report and recommendations, and discusses the merit in establishing a small working group to determine the extent of any public reporting.
5.4.2 New Senate Enquiry

‘Complaints mechanism administered under the Health Practitioner Regulation National Law’

On 1 December 2016, the Senate referred the matter to the Senate Community Affairs References Committee for inquiry and report by 10 May 2017. Submissions close 24 February 2017.

The terms of reference are:

1. the implementation of the current complaints system under the National Law, including the role of the Australian Health Practitioner Regulation Authority (AHPRA) and the National Boards;
2. whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;
3. the roles of AHPRA, the National Boards and professional organisations, such as the various Colleges, in addressing concerns within the medical profession with the complaints process;
4. the adequacy of the relationships between those bodies responsible for handling complaints;
5. whether amendments to the National Law, in relation to the complaints handling process, are required; and
6. other improvements that could assist in a fairer, quicker and more effective medical complaints process.

Commentary

The reference by government to the Senate therefore enacts Recommendation 6 of the previous enquiry. It is highly likely the Council will be invited to give evidence. If called to do so (which is different to being invited) this is compulsory.

Given the focus of this inquiry is on the implementation and regulation of the complaints mechanism administered under the Health Practitioners Regulation National Law (The National Law) the enquiry is seeking input about whether what is currently in place is satisfactory and if not why not. There is merit in Presidents discussing the type of input appropriate to submit to this new enquiry.

The following information against each of the ToRs is provided to stimulate discussion.

**ToR 1:** CPMC has previously indicated its support for the establishment of the National Law, and national regulation. The only concern previously raised about AHPRA and the MBA has been where a decision was made by one board in relation to extending the scope of practice of non-medically trained practitioners into areas of medical practice where it was considered a risk to public safety. The role of the MBA was questioned in terms of what degree of final decision-making it had over such decisions. Given that has been resolved, suggest no response to this ToR.

**ToR 2:** CPMC has not received any information which points against AHPRA as the agency to receive and manage medical complaints. The AHPRA website provides a link which sets out the process (http://www.ahpra.gov.au/Notifications.aspx) and it has improved in the provision of information over time. Suggest no comment on this ToR.
ToR3: Seeks input on the roles of AHPRA, the National Boards and professional organisations, such as the various Colleges, in addressing concerns within the medical profession with the complaints process. On this matter suggest a strong statement which sets out the approach taken by Colleges to dealing with complaints and the referral rules between the agencies.

ToR4: seeks information on the adequacy of the relationships between those bodies responsible for handling complaints. The AHPRA released a statement shortly after the enquiry was announced which said it would take the lead in developing and implementing a national, annual survey of trainees which will give them a voice, be a safe place for them to provide feedback on their training experience, and enable systemic issues such as bullying and harassment to be identified. (read it at: http://www.ahpra.gov.au/News/2016-12-01-medical-complaints-process.aspx) Given the fact they have taken the lead on this matter CPMC should indicate that is willing to work with the MBA/AHPRA on the process moving forward and recommend it works closely with health departments, and employers to develop the survey further as well as its governance structure. CPMC may wish to offer a recommendation regarding funding arrangements which should be using the AHMAC type of model which splits contributions into the process.

ToR5: whether amendments to the National Law, in relation to the complaints handling process, are required depends upon whether the current structure simply needs enhancement rather than full legislative change.

ToR6 seeks input as to whether other improvements that could assist in a fairer, quicker and more effective medical complaints process. Board may wish to offer some options to this term of reference.

Recommendation: The Board notes the background to the current enquiry and discusses the approach to be taken to responding to the new enquiry.
The Senate

Community Affairs
References Committee

Medical complaints process in Australia

November 2016
MEMBERSHIP OF THE COMMITTEE

44th Parliament

Members

Senator Rachel Siewert, Chair
Western Australia, AG

Senator Zed Seselja, Deputy Chair
Australian Capital Territory, LP

Senator Catryna Bilyk
Tasmania, ALP

Senator Carol Brown
Tasmania, ALP

Senator Katy Gallagher
Australian Capital Territory, ALP

Senator the Hon Bill Heffernan
New South Wales, LP
(from 4 February to 15 March 2016)

Senator Joanna Lindgren (to 4 February 2016)
Queensland, LP

Senator James Paterson (from 15 March 2016)
Victoria, LP

45th Parliament

Members

Senator Rachel Siewert, Chair
Western Australia, AG

Senator Jonathon Duniam, Deputy Chair
Tasmania, LP

Senator Sam Dastyari (from 10 October 2016)
New South Wales, ALP

Senator the Hon Don Farrell (to 10 October 2016)
South Australia, ALP

Senator Louise Pratt
Western Australia, ALP

Senator Linda Reynolds
Western Australia, LP

Senator Murray Watt
Queensland, ALP

Participating members for this inquiry

Senator Stirling Griff
South Australia, NXT

Senator John Madigan
Victoria, IND

Senator Peter Whish-Wilson
Tasmania, AG

Senator Nick Xenophon
South Australia, IND
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<tr>
<td>ACEM</td>
<td>Australasian College of Emergency Medicine</td>
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<td>ADA</td>
<td>Australian Dental Association</td>
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<td>AHPRA</td>
<td>Australian Health Practitioners Regulation Agency</td>
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<td>AIDA</td>
<td>Australian Indigenous Doctors' Association</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<td>AMSA</td>
<td>Australian Medical Students' Association</td>
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<td>ANMF</td>
<td>Australian Nursing and Midwifery Federation</td>
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<tr>
<td>ANZCA</td>
<td>Australian and New Zealand College of Anaesthetists</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>committee</td>
<td>Community Affairs References Committee</td>
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<tr>
<td>CPMC</td>
<td>Committee of Presidents of Medical Colleges</td>
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<td>Expert Advisory Group</td>
<td>Expert Advisory Group on discrimination, bullying and sexual harassment to the Royal Australasian College of Surgeons</td>
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<td>HCCA</td>
<td>Health Care Consumers' Association</td>
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<td>HPARA</td>
<td>Health Practitioners Australia Reform Association</td>
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<td>MBA</td>
<td>Medical Board of Australia</td>
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<tr>
<td>National Law</td>
<td><em>Health Practitioners Regulation National Law Act 2009 (Qld)</em></td>
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<tr>
<td>Ombudsman or NHPOPC</td>
<td>National Health Practitioner Ombudsman and Privacy Commissioner</td>
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<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
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<tr>
<td>NRAS or National Scheme</td>
<td>National Registration and Accreditation Scheme</td>
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<tr>
<td>RACMA</td>
<td>Royal Australasian College of Medical Administrators</td>
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<td>RACP</td>
<td>Royal Australasian College of Physicians</td>
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<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
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</tbody>
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LIST OF RECOMMENDATIONS

Recommendation 1

4.25 The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:

- acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike;
- recognise that working together and addressing these issues in a collaborative way is the only solution; and
- commit to ongoing and sustained action and resources to eliminate these behaviours.

Recommendation 2

4.27 The committee recommends that all universities adopt a curriculum that incorporates compulsory education on bullying and harassment.

Recommendation 3

4.30 The committee recommends that all universities accept responsibility for their students while they are on placement and further adopt a procedure for dealing with complaints of bullying and harassment made by their students while on placement. This procedure should be clearly defined and a written copy provided to students prior to their placement commencing.

Recommendation 4

4.32 The committee recommends that all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students and volunteers.

Recommendation 5

4.35 The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.
Recommendation 6

4.37 The committee recommends that a new inquiry be established with terms of reference to address the following matters:

- the implementation of the current complaints system under the National Law, including role of AHPRA and the National Boards;
- whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;
- the roles of AHPRA, the National Boards and professional organisations – such as the various Colleges – in addressing concerns within the medical profession with the complaints process;
- the adequacy of the relationships between those bodies responsible for handling complaints;
- whether amendments to the National Law in relation to the complaints handling process are required; and
- other improvements that could assist in a fairer, quicker and more effective medical complaints process.
Chapter 1

Introduction

Bullying and harassment in the Australian medical profession

1.1 There has been considerable focus in the Australian community in recent years on the issue of workplace bullying and harassment in the medical profession. A series of reviews and reports have indicated that bullying and harassment is a significant problem across a wide range of practice types and regions.1

1.2 On 2 February 2016, the Senate referred the medical complaints process in Australia to the Community Affairs References Committee for inquiry and report, with the following terms of reference:

(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.

Guidance on terms of reference

1.3 The committee subsequently published additional guidance on the inquiry's terms of reference, highlighting that the inquiry's focus was on the intersection between bullying and harassment in Australia's medical profession and the medical complaints process:

To guide the inquiry process, the committee would like to provide clarity on how it is interpreting the terms of reference (ToR). The overarching issue under inquiry is the prevalence of bullying and harassment within Australia's medical profession (ToR a).

The other ToR should be read according to how they relate to bullying and harassment within Australia's medical profession, and how such bullying and harassment may ultimately impact on individual medical practitioners and patient outcomes.2

1.4 That guidance further added the following additional notes on individual terms of reference:

ToR a This is the overarching issue under inquiry. The committee defines 'Australia's medical profession' as including both nurses/midwives and medical practitioners (doctors), as well as students for those professions.

ToR b Is there anything preventing medical practitioners from reporting bullying and harassment?

ToR c Are the complaints and investigation processes of the relevant medical boards, nursing and midwifery boards and AHPRA able to be used vexatiously for bullying or harassment, particularly by other medical professionals?

ToR d Does the legal framework under which the relevant medical boards and AHPRA operate have appropriate safeguards against being used vexatiously for bullying or harassment?

ToR e Has nationalising the registration and monitoring of medical practitioners improved medical care in Australia?

ToR f Should there be stronger requirements for patient outcome specific data to be used both in lodging and investigating complaints?

ToR g Is there evidence to suggest vexatious complaints are being made, and if so, what systems could be put in place to reduce the prevalence?3


1.5 The issue of bullying and harassment in Australia's medical profession received concentrated public and media attention following a series of prominent doctors making public comments about the profession's culture. Most notably, vascular surgeon Dr Gabrielle McMullin described the sexual harassment of female doctors as rife within the profession\(^4\), and neurosurgeon Dr Charlie Teo noted that bullying is 'more extreme than you've been led to believe'.\(^5\)

1.6 The committee notes there have been a number of recent inquiries into workplace bullying and harassment in Australia. Notably, the House of Representatives Standing Committee on Education and Employment inquiry into workplace bullying in 2012 highlighted that bullying was a significant issue across a range of industries and professions.\(^6\)

1.7 A 2015 report by the Expert Advisory Group established by the Royal Australasian College of Surgeons (RACS) found that 'discrimination, bullying and sexual harassment are pervasive and serious problems in the practice of surgery in Australia and New Zealand'.\(^7\)

1.8 The Australian Medical Association (AMA) suggests that the findings of the RACS survey are likely to be representative across the whole medical profession, suggesting 'anecdotal evidence and feedback from members would indicate that this experience is replicated in other medical specialties'.\(^8\)

1.9 As the submission from mental health advocacy group Beyondblue notes, the effects of workplace bullying and harassment can be serious and wide-ranging, particularly in the medical profession:

> Research shows a clear link between bullying and harassment and the experience of depression and anxiety conditions. These conditions are potentially disabling, and associated with a wide range of adverse outcomes for affected individuals, including the risk of premature death by suicide. These conditions also impact on family, friends, workplace colleagues, and on society more broadly.

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Bullying can lead to poor health and low morale, engagement and productivity among workers who witness bullying. In the medical profession the negative impacts of bullying and harassment have the potential to impact on patient care.9

Focus of the inquiry

1.10 This inquiry was established to investigate the role of the existing medical complaints process to deal with certain types of bullying and harassment. A focus for this inquiry was how the medical complaints process in Australia, overseen by AHPRA and the National Boards, has itself been misused by some medical practitioners as a form of bullying and harassment. The committee has also investigated broader questions of bullying and harassment within the profession, including its prevalence and barriers to the reporting of it.

1.11 Throughout this inquiry, the committee received examples of medical practitioners whose careers and lives have been affected by what they believe are vexatiously made complaints lodged against them by colleagues or competitors.

1.12 While concerned about the prevalence of a wide range of forms of bullying and harassment within Australia's medical profession – and the consequent effects that has on patient outcomes and public safety – the committee's focus in this inquiry has largely been on the misuse of the complaints process. The medical profession needs a robust, transparent and respected complaints process in order to ensure public safety.

National regulation and accreditation of medical practitioners

1.13 Australia's medical complaints process is a consequence of the creation of a national scheme for the regulation and accreditation of medical practitioners. In 2006, the Productivity Commission recommended the establishment of a single national registration and accreditation scheme (NRAS) to enable the Australian health workforce to deal with shortages and associated pressures; to increase its flexibility, responsiveness, sustainability and mobility; and to reduce red tape.10

1.14 The Council of Australian Governments (COAG) agreed in 2006 to establish the NRAS, to ensure that all health professionals were 'registered against the same, high-quality national professional standards' and to allow 'doctors, nurses and other health professionals to practise across state and territory borders without having to re-register'.11

1.15 COAG signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions in 2008. The scheme consisted of 'a Ministerial Council, an independent Australian Health Workforce Council, a national agency with an agency management committee, national profession-specific

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9 Beyondblue, Submission 11, p. 2.
boards, committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each state and territory (see Figure 1.1).

**Figure 1.1 – National Registration and Accreditation Scheme**

![Diagram of the National Registration and Accreditation Scheme](image)

Source: Australian Health Practitioner Regulation Agency.\(^\text{12}\)

1.16 The Department of Health outlined the objectives of the National Scheme, as set out in the establishing legislation:

- to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
- to facilitate the provision of high quality education and training of health practitioners;
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
- to facilitate access to services provided by health practitioners in accordance with the public interest; and

• to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.\(^\text{13}\)

1.17 As the Commonwealth does not have the power to regulate health professionals, the legislative framework for implementation of the NRAS was enacted by the state and territory legislatures.

1.18 The *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law) received Royal Assent on 3 November 2009. It details the substantive provisions for registration and accreditation. Other states and territories passed similar legislation to the National Law and jurisdiction-specific consequential and transitional provisions.\(^\text{14}\) The NRAS legislation replaced 65 Acts across the jurisdictions and the bodies established replaced 80 state and territory boards. Several jurisdictions made amendments to the National Law, including New South Wales which opted for retaining its own complaints system. As the NRAS is based on state and territory legislation, the Commonwealth has limited capacity to modify complaints procedures.

1.19 The NRAS commenced on 1 July 2010 for all States and Territories except Western Australia, which joined the NRAS on 18 October 2010.

**Improving health outcomes and patient safety**

1.20 The NRAS was originally recommended as a productivity measure by the Productivity Commission.\(^\text{15}\) However, in implementing the scheme, COAG emphasised the scheme's purpose in protecting health consumers and stated:

> The new scheme will deliver many benefits to the Australian community including health consumers. National standards in each profession will mean stronger safety guarantees for the community. Patients will know that wherever the health professional is from, they are registered against the same, high-quality national professional standards.\(^\text{16}\)

1.21 As the Department of Health noted, the NRAS is one element of Australia's health system, but it does have particular responsibility for the protection of the public:

> This Scheme for the first time initiated nationally consistent standards for the registered professions, provided mobility for professionals to work across jurisdictions and allowed the development of a national public register of registered health professionals.\(^\text{17}\)

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1.22 From the perspective of the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the Australian Health Practitioner Regulation Authority one of the National Scheme's notable achievements is improved outcomes for patients via greater public protection:

… a national on-line register of practising practitioners and cancelled health practitioners which can be accessed by the public at any time, and prevents health practitioners who have committed misconduct and faced regulatory action to practise undetected in other states or territories.18

Creation of the Australian Health Practitioner Regulation Agency

1.23 The Australian Health Practitioner Regulation Agency (AHPRA) was established as the national agency responsible for implementation and ongoing management of the NRAS, and currently oversees 14 professions, including medical practitioners and nurses/midwives. The 14 National Boards currently part of the NRAS are:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia;
- Chinese Medicine Board of Australia;
- Chiropractic Board of Australia;
- Dental Board of Australia;
- Medical Board of Australia;
- Medical Radiation Practice Board of Australia;
- Nursing and Midwifery Board of Australia;
- Occupational Therapy Board of Australia;
- Optometry Board of Australia;
- Occupational Therapy Board of Australia;
- Pharmacy Board of Australia;
- Physiotherapy Board of Australia;
- Podiatry Board of Australia; and
- Psychology Board of Australia.19

1.24 AHPRA has the following roles:

- maintaining up-to-date and publicly accessible national lists of accredited courses and registered practitioners with entries relating to individuals to include any conditions or restrictions on professional practice;

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18  Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 8.

• administering the resources of the scheme and ensure the scheme is as efficient as possible;
• acting in accordance with any policy directions from the Ministerial Council;
• reporting annually to the Ministerial Council;
• following agreement with the boards, setting fees, and where there is no agreement, referring this to the Ministerial Council;
• at its discretion, contracting or delegating functions, excluding registration and accreditation functions, with any delegations reported to the Ministerial Council;
• in consultation with the boards, developing and administering procedures and business rules for the efficient and quality operation of the registration and accreditation functions and the operation of the boards and their committees, consistent with ministerial policy direction and the objects of the legislation;
• in accordance with the objects of the legislation and any policy directions of health ministers, set frameworks and requirements for the development of registration, accreditation and practice standards by the national boards to ensure that good regulatory practice is followed;
• advising the Ministerial Council on issues relevant to the scheme; and
• establishing a national office.20

National Boards and the regulation of individual practitioners

1.25 There is a National Board for each of the 14 regulated health professions. National Board members are appointed by the Ministerial Council. At least half, but not more than two thirds of National Board members must be practitioner members and the remaining members are appointed as community members to ensure a degree of oversight from people outside the profession. Members of State and Territory Boards (Professional Boards) are appointed by the Minister for Health in each jurisdiction, with the same requirement for ratios of community members.

1.26 The functions of the Boards focus on protecting the public and guiding the professions. This includes responsibilities for registering health practitioners who meet the requirements of approved registration standards, investigating and managing concerns (known as notifications) about the performance, health or conduct of practitioners and developing standards, codes and guidelines. National Boards have delegated many functions to AHPRA and Board committees (national or State and Territory or regionally-based) to support the efficient functioning of the National Scheme. Registrations and complaints procedures are delegated from the National Board to the relevant state or territory Boards.

Reviews of the NRAS

2011 Senate Finance and Public Administration References Committee inquiry

1.27 In June 2011, just under a year after the NRAS took effect, the Senate Finance and Public Administration References Committee reported on its inquiry into the administration of health practitioner regulation by AHPRA. That report acknowledged the scale of the undertaking, but highlighted that implementation of the NRAS had been problematic.21

1.28 The committee wrote:

The committee points to the impact on patients and health service provision as yet another example of the serious implications of AHPRA's administrative failures. The committee notes that it has exacerbated patient waiting times, and compromised health service provision, particularly in rural and remote communities which are already particularly vulnerable.22

1.29 The committee made ten recommendations, including one relevant to this inquiry's focus:

Recommendation 5

The committee recommends that complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.23

2014 Independent review

1.30 In 2014, the National Scheme was reviewed by an Independent Reviewer, Mr Kim Snowball. The final report of this review was published in 2015 and made 33 recommendations. The Australian Health Workforce Ministerial Council accepted the two recommendations specifically related to AHPRA's notification and investigation process.24

1.31 The first of these, Recommendation 9, concerned increased and improved communication from AHPRA to both the notifier and the medical practitioner,

21 Senate Finance and Public Administration References Committee, Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency, June 2011, p. 111.

22 Senate Finance and Public Administration References Committee, Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency, June 2011, p. 81.

23 Senate Finance and Public Administration References Committee, Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency, June 2011, p. xi.

including establishing the notifier's expectation for matters referred to a National Board. The Ministers asked AHPRA to 'action this recommendation as a matter of priority and provide a progress report by December 2015'.

1.32 Recommendation 28 was that AHPRA should, in consultation with the National Boards, Tribunals and Panel members, conduct specific education and training programs for its investigators, with the aim of developing 'more consistent and appropriate investigative standards and approaches... including the primacy of public safety over other considerations within the matters'. The ministerial council accepted this recommendation and requested a progress report from AHPRA by December 2015.

1.33 In their submission, the Medical Board, Nursing and Midwifery Board and AHPRA recognised that:

… the management of notifications and complaints has not always met community expectations, including concerns about delays in the management of some notifications and confusion in roles with partners such as the health complaints entities.

1.34 Consequentially, they have been working to improve the process, particularly in terms of timeliness and communication. They identified three main areas in which improvements were being made:

- implementing processes that deliver early triage of notifications and greater clinical input to ensure we continue to improve the timeliness of assessment of notifications;
- working with health complaints entities to ensure roles and processes are as clear as possible for notifiers and practitioners. A common assessment matrix has been developed and agreed to determine which entity is best placed to manage each matter and public information has also been produced; and
- correspondence with notifiers and practitioners has been reviewed and improved and more meaningful progress reports are now being provided to notifiers and practitioners during the course of investigations.

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28 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.

29 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.
Conduct of the inquiry

1.35 The inquiry was referred to the committee on 2 February 2016, with a reporting date of 30 June 2016 set.\textsuperscript{30} It lapsed with the dissolution of the 44\textsuperscript{th} Parliament on Monday 9 May 2016 and was re-referred by the Senate on 15 September 2016.\textsuperscript{31} A new reporting date of 16 November 2016 was set, but was subsequently extended until 30 November 2016.\textsuperscript{32}

Handling of submissions

1.36 The committee invited submissions to be lodged by Friday 13 May 2016. Following the inquiry's lapse and re-referral, the committee decided not to formally call for further submissions but continued to accept submissions.

1.37 In total, the committee received 129 submissions from individuals and organisations. A list of submissions to the inquiry is available at Appendix 1.

1.38 The committee received a number of submissions from individual medical practitioners, as well as from family members or others on their behalf, discussing their personal experience of bullying and harassment, including via the complaints process. The majority of these submissions provided detailed accounts of individual cases.

1.39 To respect the privacy of those submitters, as well as of other medical practitioners, patients and employees of the health system, the committee decided to accept all such submissions in confidence. While individual cases and examples will not be referred to in this report, the committee acknowledges the concerns expressed by those who made submissions to this inquiry. These submissions assisted the committee to gain a firsthand understanding of the issues involved – the ways in which the complaints process has been implemented, concerns about AHPRA's management of the assessment and investigation process and the effects on practitioners' careers and lives as a result.

1.40 The committee also held two public hearings: one in Sydney on 1 November 2016 and a second in Canberra on 22 November 2016. Transcripts of those hearings are available on the committee's website and a list of witnesses who gave evidence is provided in Appendix 2. The committee acknowledges and thanks all those who contributed to this inquiry by providing written submissions or appearing at the public hearings.

Structure of this report

1.41 Following this introductory chapter, this report consists of three further chapters.

1.42 Chapter 2 outlines the medical complaints process in Australia, discussing the process of assessing and investigating complaints – known as notifications – lodged

\textsuperscript{30} Journals of the Senate, No. 135–2 February 2016, pp 3661–3662.

\textsuperscript{31} Journals of the Senate, No. 7–15 September 2016, pp 224–225.

\textsuperscript{32} Journals of the Senate, No. 15–10 November 2016, p. 451.
against medical practitioners and how vexatious complaints are dealt with. It then
discusses concerns with this process, specifically in relation to its relationship to
bullying and harassment. In particular, this chapter draws on evidence the committee
received which suggests that the complaints process – the making of a notification and
the investigation by AHPRA and other bodies – can be itself used as a tool of bullying
and harassment within the profession. The chapter then discusses the ramification of
this, including its negative impacts on practitioners' careers and lives and
consequences for patient safety.

1.43 Chapter 3 addresses broader questions of bullying and harassment in
Australia's medical profession, including the responses to these made within the
profession itself.

1.44 Chapter 4 discusses the broader context of this inquiry, noting that this inquiry
into the intersection of the medical complaints process and the prevalence of bullying
and harassment within the profession has drawn the committee's attention to systemic
questions and concerns about the medical complaints process in Australia as a whole.
The chapter outlines areas the committee considers to require further investigation that
is beyond the scope of this inquiry's terms of reference.
Chapter 2

The complaints process as a tool of harassment

Introduction

2.1 A key focus of this inquiry was the ways in which the medical complaints process in Australia, particularly that run by the Australian Health Practitioner Regulation Agency (AHPRA) and the medical boards, may have been used as a tool of harassment within the medical profession. The committee received a considerable amount of evidence suggesting that one form of bullying and harassment within the medical profession is for one practitioner to lodge a notification against another with AHPRA, possibly leading to an investigation and findings against the latter.

2.2 This chapter will outline AHPRA's complaints process, identified by submitters as being vulnerable to be used for the purpose of bullying and harassment, and the option for the review of AHPRA's decisions through the National Health Practitioner Ombudsman and Privacy Commissioner. The chapter will then discuss the concerns with this process as identified by submitters and witnesses to this inquiry, including the lodging of vexatious complaints; timeliness; transparency and communication; conflicts of interest; qualifications of the investigators and the use of benchmarking.

Complaints procedures

2.3 Anyone can make a complaint (also called a notification) about a registered health practitioner's health, performance or conduct. The management of these notifications is a joint responsibility of AHPRA and the relevant National Board.1 AHPRA is responsible for investigating registered health practitioners and providing information for the National Board to consider in making its decision.2

2.4 Different National Boards have delegated some of their decision-making to their State/Territory committees and AHPRA officers. There are a number of possible stages in the notifications process and they do not need to be completed in a linear sequence, nor does every notification go through all the possible stages. Many notifications are closed after assessment.

2.5 In New South Wales, complaints against health care practitioners are handled by the Health Care Complaints Commission. These complaints are handled in a process similar to those received by AHPRA.3

2.6 In Queensland, the Office of the Health Ombudsman is responsible for managing serious complaints relating to health practitioners, and determines which

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1  Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 4.
2  Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 4
complaints go to AHPRA and the National Boards after assessing their severity. AHPRA must then refer back to the Office of the Health Ombudsman any complaint where, during investigation, a suspicion of professional misconduct is developed.\(^4\)

2.7 Decisions made at the state level in New South Wales and Queensland regarding a practitioner's conditions of practice or registration will be communicated to AHPRA for inclusion on the AHPRA public register of health practitioners.\(^5\)

2.8 AHPRA's notification process can be seen illustrated in Figure 2.1, noting that interim or final action can be taken at any point in the process.

**Figure 2.1 – AHPRA notification process**

Source: Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 15.

2.9 In the Acceptance stage, the notification is received and a preliminary review is undertaken to confirm that the matter is grounds for notification, that it relates to a registered health practitioner (or student) and whether it could also be made to a health complaints entity.\(^6\) Generally, at this point the practitioner about whom the notification has been made will be asked to respond, unless the issue relates to a matter that the Board cannot deal with or AHPRA is concerned that the notification

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5 Department of Health, *Submission 13*, p. 3.

6 Health complaints entities (HCE)s are state and territory-based bodies whose role is to investigate concerns about health service providers or systems. Regarding individual practitioners, HCEs can investigate specific concerns, primarily around fees and charges; they do not deal with issues relating to patient safety or practitioner registration. AHPRA and HCEs share information regarding complaints more relevant to the other, and sometimes will run a joint investigation. See: [http://www.ahpra.gov.au/Notifications/Further-information/Health-complaints-organisations.aspx](http://www.ahpra.gov.au/Notifications/Further-information/Health-complaints-organisations.aspx)
raises issues that might pose a serious risk to the public, in which case the relevant National Board can take immediate action to protect the public.\(^7\)

2.10 Once a notification has been accepted, it enters the Assessment stage. AHPRA may ask for more information, and will usually send the relevant practitioner a copy of the notification unless it would prejudice the investigation or place a person at risk. AHPRA presents the information to the Board for consideration, and the Board can either close the notification with no further action taken, propose to take relevant action (such as cautioning the practitioner, imposing conditions on their registration or accepting undertakings from them),\(^8\) or refer the matter to the next stage of Investigation, Health Assessment or Performance Assessment. AHPRA aims to complete the Assessment stage for each notification within 60 days. Proposing to take a relevant action, however, can extend that timeframe, since the practitioner will be given the chance to show cause as to why that action should not be taken.\(^9\)

2.11 If the Board is not satisfied with the amount of information it has been provided with at the Assessment stage, it can refer the notification back to AHPRA for Investigation, Performance Assessment or a Health Assessment. Investigations are carried out by AHPRA officers and seek additional information to aid the Board in its decision making. This information can take many forms, including additional information from the notifer and/or practitioner, information from other health practitioners involved, independent expert opinions or other information such as Medicare data or police records. Once the investigation is complete, the Board seeks to form a reasonable belief as to whether the practitioner has behaved in a way that constitutes unsatisfactory professional performance, unprofessional conduct or professional misconduct, or if they have a health impairment. If the Board cannot make such a judgement, it may decide to take no further action. AHPRA’s aim is to complete each investigation in six months, but it notes that complex investigations make take longer. At six, nine and twelve months, each investigation is audited to ensure that it is proceeding appropriately.\(^10\)

2.12 A Health Assessment is undertaken if the practitioner's health is suspected to be impaired and impacting their professional performance, particularly as it relates to patient safety. Practitioners have the right to make submissions to the Board as part of the Health Assessment stage and the results of the assessment are discussed with

\(^7\) Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 16.

\(^8\) Examples of conditions that may be imposed include the completion of additional training, undertaking a period of supervised practice, managing their practice in a specified way or reporting at regular times on their practice. Undertakings are voluntary and relate to limitations on the practitioner's practice. Both conditions and undertakings are noted on the national register. See: [http://www.ahpra.gov.au/Support/Glossary.aspx](http://www.ahpra.gov.au/Support/Glossary.aspx)

\(^9\) Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 17.

\(^10\) Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, pp 18–19.
them. Boards have a range of options for action after undertaking a health assessment, including taking no further action; cautioning, accepting an undertaking from, or imposing conditions on, the practitioner; referring the matter to another entity; investigating further; requiring a Performance Assessment; or referring the matter for hearing by either a panel or tribunal.\textsuperscript{11}

2.13 A Performance Assessment is carried out by one or more independent practitioners to assess the knowledge, skill, judgement and care demonstrated by the practitioner. As with a health assessment, the results are discussed with the practitioner, and the Board has the same range of options open to it at the assessment's completion.\textsuperscript{12}

2.14 Matters relating to a notification about a health practitioner can also be referred by the Board to a panel – either a health panel if the practitioner is believed to have an impairment affecting their performance or a performance and professional standards panel if a Board believes that the practitioner's practice or professional conduct may be unsatisfactory. The panel then has the same powers of the Board and additionally can issue a reprimand of the practitioner. Reprimands, like conditions and undertakings, appear on the national public register of practitioners.\textsuperscript{13}

2.15 If a Board finds that a practitioner's conduct amounts to professional misconduct, the matter must be referred to a Tribunal hearing. Tribunals are headed by a judge or magistrate and include at least one professional representative and one community representative.\textsuperscript{14} Like panels, tribunals have broad powers, but can also cancel the registration of a practitioner.\textsuperscript{15}

\textbf{Mandatory notifications}

2.16 Under the National Law, health practitioners, employers and education providers have mandatory reporting responsibilities to advise AHPRA or a National Board if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession.

2.17 Notifiable conduct by registered health practitioners is defined as:

- practising while intoxicated by alcohol or drugs;
- sexual misconduct in the practice of the profession;

\textsuperscript{11} Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, \textit{Submission 21}, p. 19.

\textsuperscript{12} Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, \textit{Submission 21}, p. 20.

\textsuperscript{13} Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, \textit{Submission 21}, p. 20.

\textsuperscript{14} The Tribunal is the relevant administrative review tribunal in the state or territory. See: \url{http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Tribunal-hearing.aspx}

\textsuperscript{15} Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, \textit{Submission 21}, p. 21.
• placing the public at risk of substantial harm because of an impairment (health issue); or
• placing the public at risk because of a significant departure from accepted professional standards.16

2.18 Education providers have an obligation to make a mandatory notification about a student if the student has an impairment that may, either in the course of study or clinical training, place the public at substantial risk of harm.17

Statistics on notifications

2.19 AHPRA received 3,147 notifications about medical practitioners and 1,435 about nurses and midwives in 2015-16. Of these:

• 369 (11.7%) of the notifications about medical practitioners were made by other medical practitioners and 620 (43.2%) of those about nurses and midwives were lodged by other nurses and midwives (these figures include self-disclosures);18

• 33 of the 3,147 notifications about medical practitioners and 30 of the 1,435 notifications about nurses and midwives identified bullying and harassment as a primary reason for the notification;19

• 32.5% of the notifications completed by AHPRA in 2015-16 received a full investigation or a specialised assessment. The remainder were closed following assessment;20

• 3.2% of complaints received by AHPRA in 2015–16 led to a panel hearing and 3.5% a tribunal hearing.21

2.20 These statistics demonstrate that the majority of notifications lodged—particularly against medical practitioners, less so regarding nurses and midwives—were from members of the public. Just under 12 per cent of the notifications lodged against medical professionals came from colleagues.

16 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 14. Note: In Western Australia there is no legal requirement for treating practitioners to make mandatory notifications about patients (or clients) who are practitioners in one of the regulated health professions.


18 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 6.

19 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 4.

20 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 5.

21 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 21.
2.21 While the proportion of notifications lodged to AHPRA regarding bullying and harassment was low, this should not be taken to suggest that bullying and harassment levels are low, but rather illustrates that AHPRA's primary purpose relates to public safety. Bullying and harassment allegations would, in most cases, be more relevant to investigate through the individual workplace or the relevant professional college.

**Review of decisions**

2.22 The National Health Practitioner Ombudsman and Privacy Commissioner (the Ombudsman) is an independent statutory agency created to provide ombudsman, privacy and freedom of information oversight of the agencies of the National Scheme, including AHPRA and the National Boards. As such, the Ombudsman handles complaints from people dissatisfied with an AHPRA decision. The Ombudsman's submission outlines the actions of AHPRA or a National Board that may be the subject of a complaint:

- the actions taken by AHPRA to assess and investigate notifications or complaints made under the National Law;
- the actions of a National Board when making a decision in relation to matters raised as a result of a notification or complaint; and
- the actions of a National Board when making a decision to refuse registration or place conditions on the registration of a health practitioner.

2.23 Ms Samantha Gavel, current (and first) Ombudsman, further outlined her responsibilities and powers, emphasising that the Ombudsman's office is focused on AHPRA's procedures, rather than the details of the original complaint:

> It is important to note that the role of my office is not to review the conduct or performance of health practitioners; that is the role of the national boards. The role of my office is to consider the administrative actions of AHPRA and the board in relation to action that is subject of a complaint. We examine whether AHPRA and the board have acted consistently with applicable legislation, have complied with relevant policies and procedures and have taken relevant considerations into account. In particular, we look at whether AHPRA has gathered sufficient information during its investigation to inform the board's decision making and whether the board's decision is reasonable based on the information gathered by AHPRA.

2.24 Actions open to the Ombudsman include recommending that AHPRA and the National Boards:

- reconsider a decision;
- review or change a policy or procedure;

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22 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 5.
24 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, Committee Hansard, 1 November 2016, p. 2.
• offer an apology to an affected person;
• expedite a delayed action; and
• provide a better explanation to a person affected by a decision of AHPRA or a National Board.  

2.25 However the Ombudsman can only make those recommendations; it cannot overturn an AHPRA or National Board decision or force a review. Further, in New South Wales, the Ombudsman has no jurisdiction to respond to complaints (complaints there are handled by the New South Wales Health Care Complaints Commission) and in Queensland can only respond if the matter is transferred from the Queensland Office of the Health Ombudsman.  

2.26 In 2014–15, the Ombudsman received a total of 75 complaints. The largest category of these (35 cases, or just under 47%) was from notifiers unhappy with the result of their notification about a practitioner; while 17 (or just under 23%) were from practitioners regarding the handling of a notification against them. The majority of the remainder was related to registration issues from individual practitioners.  

2.27 The 2015–16 figures showed 40 per cent of complaints came from members of the public concerned about the results of their notification against a health practitioner. A further 14 per cent were from health practitioners who had been the subject of a notification, and 34 per cent related to registration issues. From 2014–15 to 2015–16, therefore, there was a slight drop in the proportion of complaints received by the Ombudsman from practitioners regarding the way a notification against them had been managed.  

2.28 The Ombudsman also has a role in providing feedback to AHPRA and the National Boards about systemic issues identified from complaints received and helping those bodies to improve their processes.  

Vexatious complaints handling  

2.29 One of the key issues identified in evidence received by this inquiry is that of vexatious complaints. Multiple witnesses argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment. In this section, AHPRA's process for identifying and handling vexatious complaints will be outlined.  

2.30 Section 151 of the National Law authorises National Boards to take no further action on any notification if it reasonably believes it to be vexatious or frivolous.  

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25 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 7.  
26 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 7.  
27 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 8.  
28 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 9.  
29 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, Committee Hansard, 1 November 2016, p. 2.  
30 Department of Health, Submission 13, p. 3.
Section 237 protects those who make a notification in good faith. However, as the joint submission from the Medical Board, Nursing and Midwifery Board and AHPRA notes, classifying notifications as vexatious is not straightforward:

However, determining that a notification is vexatious can be difficult, and hence data on vexatious complaints and notifications are difficult to quantify. For example, a complaint may relate to performance and risks to public safety but there may be elements of self interest from a notifier in relation to their professional or commercial interests.\(^{31}\)

2.31 The Ombudsman noted that ready access to the complaints mechanism is important for public health and that, while complaints can be lodged vexatiously, there is limited evidence of this happening often:

… the NHPOPC's [National Health Practitioner Ombudsman and Privacy Commissioner] experience in handling complaints about the administrative actions of AHPRA and the National Boards does not suggest that there is a high incidence of people intentionally using notification processes for vexatious purposes.\(^{32}\)

2.32 Mr Martin Fletcher, Chief Executive Officer of AHPRA, made a similar point, drawing on existing research:

What I am saying is that in all of the available data and research evidence that we have looked at there does not appear to be a big problem with vexatious complaints, and by 'vexatious' I mean a harmful intent on the part of the person making the complaint and no patient safety concern emerging when we look at the issue.

[…]

If I can give you one example, we have a research partnership with the University of Melbourne. They looked at 850 mandatory notifications over a 12-month period. They found fewer than six that they believed potentially met the criteria for a vexatious notification. The point I am also making is that, even though the numbers are small, we recognise that the impact on the individuals involved can be significant.\(^{33}\)

2.33 The Ombudsman also pointed to existing safeguards against the making of vexatious complaints; in addition to the provision authorising National Boards to take no further action on complaints it deems vexatious or frivolous:

Other provisions include the requirement for a national board to undertake a show-cause process in some circumstances and the ability of a health

\(^{31}\) Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 27, p. 6.

\(^{32}\) National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 13.

\(^{33}\) Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, Committee Hansard, 1 November 2016, p. 3.
practitioner to appeal most types of regulatory action to a tribunal or court.  

2.34 The Ombudsman further noted that even some vexatiously made complaints may raise issues of public safety and expressed its confidence in the notification assessment and investigative processes of AHPRA and the National Boards in ensuring the protection of the public.  

2.35 AHPRA noted in this context that soon after the completion of this inquiry, it will launch a portal for the lodging of complaints online, which will also ‘… invite a declaration from the notifier that the content of their complaint or concern is true and correct to the best of their knowledge and belief.’ A corresponding change will be made to the hard copy complaint form at the same time.  

2.36 AHPRA further noted that it will monitor the impact of this addition to 'ensure there are no unintended consequences for people wanting to raise concerns about registered health practitioners'.  

2.37 Similarly, AHPRA explained that, to better identify and understand the problem, it will commission research into vexatious notifications:  

As we have previously advised the committee, the data we have and the available research indicate this is a very small problem, but we recognise it has a big impact when it happens. We will publish what we learn and act on it.  

2.38 Mr Fletcher further noted that a process is underway to more specifically prohibit the making of vexatious complaints by medical practitioners:  

… the Medical Board will toughen its code of conduct in relation to vexatious complaints. Establishing a clear benchmark will enable the board to take further action against a practitioner who makes complaints purely to damage another registered practitioner.  

Committee view  

2.39 The committee recognises that vexatious complaints are not always readily apparent, but is not convinced that AHPRA's processes are adequate for the purpose of identifying complaints made vexatiously.  

34 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, Committee Hansard, 1 November 2016, p. 2.  
35 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 13.  
36 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 10.  
37 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 10.  
38 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, Committee Hansard, 1 November 2016, pp 1–2.  
39 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, Committee Hansard, 1 November 2016, p. 2.
Vexatious complaints as a form of bullying and harassment

2.40 The committee has received a considerable amount of confidential evidence suggesting that the complaints process can be used as a tool of bullying and harassment within Australia's medical profession.

2.41 A significant proportion of confidential submitters claim that vexatious complaints have been made against them either internally within the workplace or through the formal processes of AHPRA to bully or harass them. In particular, submitters allege that notifications were lodged against them in response to their own complaints of bullying and harassment.

2.42 Confidential submitters are concerned that there is no avenue for AHPRA to counsel complainants on false or misleading allegations and that there are no consequences for individuals who make vexatious complaints. Some confidential submitters consider it would be beneficial if a record of vexatious complainants was kept and suggest that legal action should be taken against people found to have submitted vexatious complaints.

2.43 Dr Don Kane, Chair of the advocacy group Health Practitioners Australia Reform Association (HPARA), argued that this is a substantial problem for medical practitioners:

> These people [those making vexatious complaints] are misusing AHPRA for their own personal reasons. It is very rare, if ever, that AHPRA have taken action against people who have lodged vexatious claims. There is an absolute abuse of the mandatory notification process. It was put in there in the guise of being in the public interest, but really it is in the interests of the people making the complaint.40

2.44 The Medical Board of Australia and AHPRA responded to this concern, arguing that their primary concern is in ensuring patient and public safety and that any weakening of the notification and investigation process would undermine that:

> It has been alleged that the way AHPRA and the boards deal with complaints is a form of bullying. We reject this allegation. We fully accept that it is our responsibility to make sure we deal with notifications fairly and efficiently. We have worked hard to improve the timeliness of our processes and to improve our communication with both notifiers and practitioners. We have streamlined how we work with other health complaints entities to make sure that the right body is managing the complaint from the outset.

> But our primary focus is patient safety. Notifications that raise serious issues must be dealt with rigorously, and we must take appropriate regulatory action where there is a risk to the public. The community comes to us with their concerns when they have had a bad experience or a bad

40 Dr Don Kane, Chair, Health Practitioners Australia Reform Association, Committee Hansard, 1 November 2016, p. 39.
outcome. They want us to take their concerns seriously and to take action to ensure that whatever happened to them does not happen again.41

Concerns with AHPRA's complaints process

2.45 Many confidential submissions express concern about AHPRA's management of vexatious complaints, as those submitters are concerned that the complaints process is misused as a vehicle to bully and harass medical professionals.

2.46 Conversely, confidential submissions from family members of patients expressed concern that their genuine complaints had resulted in lenient consequences for the medical practitioners concerned.

2.47 The issue of the AHPRA complaints handling process, including the identification of vexatious complaints, was reviewed during the 2011 Finance and Public Administration References Committee Inquiry into AHPRA. The committee commented:

The committee is concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.42

2.48 The committee recommended:

[T]hat complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.43

2.49 The Government response to the inquiry report did not provide any comments specific to this recommendation.44

2.50 Discussing that committee's findings and recommendations, the Ombudsman, Ms Samantha Gavel, noted that considerable improvements had been made in AHPRA's processes since 2011, when the National Scheme was still new:

I think we all know that there were problems with the notification process in the first few years of the scheme. I certainly know that from the reading I have done, and I have had a look at some of those reports. Since I came into

41 Dr Joanna Flynn, Chair, Medical Board of Australia, Committee Hansard, 1 November 2016, p. 54.

42 Senate Finance and Public Administration References Committee, Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency, June 2011, p. 93.

43 Senate Finance and Public Administration References Committee, Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency, June 2011, p. xi.

the role, which was two years ago now, I have seen a big improvement in notification processes. […]

I have seen a big improvement in all sorts of areas. They have put a number of new policies and processes in place. For example, they have done more training for their staff that take calls on the phone so that they are better able to talk people through the national law, the notifications process and what they can expect. They can keep them better informed about what is occurring. They are now providing far more detailed outcome letters, which is important so that people understand what the board has looked at and why they have come to the decisions that they have. They are some of the areas where I have seen improvements.45

2.51 Despite this, the committee is concerned by the proportion of submitters to this inquiry who identified serious concerns with AHPRA's management of the notification and investigation process, particularly when in relation to notifications lodged vexatiously, as a tool of bullying and harassment. This section will outline those concerns.

**Timeliness**

2.52 Confidential submitters complained of long timelines for AHPRA investigations to be completed, ranging from two to four years. The slow timeframes concerns both those who have made complaints and those who have had complaints made against them. The former want to see incompetent practitioners quickly dealt with in a manner that protects the public. The latter are concerned that competent doctors' time and energy is being wasted responding to false accusations.

2.53 As noted above, AHPRA's target is to complete each investigation within six months. Ms Kym Ayscough, the Acting Chief Executive Officer, noted that the agency is aware of concerns in this area and pointed to the median age of open notifications as being 137 days:

> In the material that we have to 30 June 2016, the median age of open notifications is 137 days, and that is a five-day reduction in median age from the same time last year. This has been a particular area of focus for us. We know there was a lot of criticism, in the early days, of the national scheme about the time frames, and we have continued to work diligently, both AHPRA and the boards, to bring those time frames within reasonable expectations.46

2.54 Organisations also commented on this aspect of the complaints process. For example, the Australian and New Zealand College of Anaesthetists argued that:

> In this area justice delayed is justice denied.

45 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 4.

46 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 55.
It is important for the health professional to have any concerns speedily dealt with; at the same time if the concerns are sustained, then it is important for public protection that appropriate action is taken, including changes to the registration status.47

Similarly, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) also argued that timeliness of investigation is both vital and frequently absent:

Timely and necessary action in response to complaints is important in providing effective public protection and confidence in the National Law on the part of both practitioners and patients.

An ongoing problem is the length of time it takes to investigate and resolve complaints. In recent years, investigations have taken far too long, causing unnecessary stress for both complainants and practitioners under investigation and leaving both in the dark as to the outcome.48

RANZCP further noted that AHPRA often does not communicate well and promptly with them regarding the investigation of RANZCP members.49

The Australian Dental Association (ADA) argued that the length of time investigations can take can have a deleterious effect on both notifier and practitioner:

The ADA considers the time AHPRA takes to deal with all cases is generally excessive and so management of notifications must be improved. This creates a burden of uncertainty for both the complainant and the health practitioner in question. What the current processes inadequately recognise is the impact of the complaints process on health practitioners, particularly in cases where complaints are unfounded. Practitioners not only have to invest time in defending complaints, they correspondingly experience the personal burden of shame, humiliation & psychological stress. There should be greater effort on a need to support practitioners during the notifications process, such as outlining to them expectations as well as providing timely updates on what the next phase of the process would involve and when that would occur. We are aware that AHPRA is reviewing its processes in this regard.50

Conversely, some confidential submitters complained about onerous requirements to produce documents to the investigative team on short notice.

Committee view

The committee recognises that AHPRA has improved its processes and that the timeframe for the closing of notifications has decreased in recent years. However, given the importance to both notifier and practitioner of timely resolution to each case,

47 Australian and New Zealand College of Anaesthetists, Submission 5, p. [3].
48 Royal Australian and New Zealand College of Psychiatrists, Submission 19, p. 2.
49 Royal Australian and New Zealand College of Psychiatrists, Submission 19, p. 2.
50 Australian Dental Association, Submission 6, [p. 3].
the committee considers this issue to be of the highest significance and an area for
continued monitoring and review.

**Transparency and communication**

2.60 Many confidential submitters claim the investigative process lacks
transparency and scrutiny. A few note unsuccessful attempts to be provided with all
information in relation to an allegation against them or to seek clarification of the
details of their case. Some claim evidence is taken on face value and that those
accused are not given the opportunity to respond to claims made in the investigation.

2.61 One illustration of this point came from Dr Gary Fettke, who discussed the
problems he faced when trying to respond during AHPRA's investigation of his
practice:

> The AHPRA process has shifting goalposts for those under investigation.
You answer one allegation and another one surfaces. Trying to defend one's
position without knowing the evidence and its accuracy makes for a star
chamber circus.51

2.62 AHPRA acknowledged that its management of notifications 'has not always
met community expectations' and outlined its efforts to improve, particularly in
relation to timeliness and communication:

- implementing processes that deliver early triage of notifications and greater
clinical input to ensure we continue to improve the timeliness of assessment of
notifications;
- working with health complaints entities to ensure roles and processes are as
clear as possible for notifiers and practitioners. A common assessment matrix
has been developed and agreed to determine which entity is best placed to
manage each matter and public information has also been produced; and
- correspondence with notifiers and practitioners has been reviewed and
improved and more meaningful progress reports are now being provided to
notifiers and practitioners during the course of investigations.

Improvements have been made. However, complex matters will take time
to investigate and not all matters can be finalised quickly. It is important
that investigations are robust, as the implications for the practitioner being
investigated and the notifier alike are significant.52

2.63 Dr Joanna Flynn, Chair of the Medical Board of Australia, further outlined
steps that have been taken to improve communication with practitioners who are the
subject of notifications, including a more concerted effort to communicate more often
and giving practitioners a single point of contact with AHPRA:

> One of the clear concerns that was expressed, when we started this work,
was the impersonal nature of the communication, the infrequent

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51 Dr Gary Fettke, Committee Hansard, 1 November 2016, pp 14–15.
52 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA,
Submission 21, p. 7.
communication and the feeling that practitioners were a bit at sea and did not understand what was happening. That goes back to the point I made earlier about how stressful it is and us recognising how stressful it is to be subject to a notification.

We have done a lot of work to change the culture in the organisation and to change the method of communication so there is more verbal communication, there is more frequent communication and people are given an unidentified officer with whom they can follow up their concerns. We do have staff turnover at times and sometimes there is discontinuity but, wherever possible, we try give somebody one point of contact that they can follow up with, and we try to respond to things in a much more timely and helpful way. We do recognise it is stressful, and a lack of information about what is happening and the lack of a sense that you can speak to anybody about what is going on is one of the things that adds to that stress.\(^\text{53}\)

*Committee view*

2.64 Alongside timeliness, the committee notes that the level and style of communication with both notifiers and practitioners has been one of the key concerns raised about AHPRA's management of complaints. The committee notes that AHPRA and the national boards have recognised that clear and frequent communication is a vital component of the notification process. For both the notifier and the practitioner, understanding the progress and likely outcomes will help reduce stress and uncertainty. Unfortunately, from the evidence the committee has received, there are ongoing issues with some cases. Many people have suggested there is a need for more change.

*Adversarial nature of the notification process*

2.65 Multiple witnesses identified that one concern with the medical complaints process in Australia is that it is based on adversarial and investigative systems rather than mediation or other options for resolving disputes.

2.66 The Australasian College of Emergency Medicine (ACEM) noted that the process discourages local investigation and solutions:

\[\ldots\] there is no gradual escalation of a complaint, rather the mandatory notification legislation recommends rapid referral to AHPRA. This process also denies the individual against whom the complaint has been made the opportunity to respond or attempt to locally resolve the complaint prior to its escalation to AHPRA.\(^\text{54}\)

2.67 ANZCA similarly argued that the existing process is too heavily focused on adversarial and investigative principles, rather than on addressing the issues raised in the notification and the performance of the practitioner:

\(^\text{53}\) Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 56.

\(^\text{54}\) Australasian College of Emergency Medicine, *Submission 4*, p. 3.
Communication and support are vital. This is both for the public who have raised the concern and the practitioner about whom the concern is raised. These complaints are often devastating to both parties. Everything should be done to reduce this stress and the time over which any investigation lasts.

There needs to be a substantial move from the adversarial and legally based system that is currently evident to one that is focused on conciliation and rapid resolution wherever possible. There is no doubt that the concerns, aggravation and angst of complaints are magnified enormously when delays are multiplied and the process becomes adversarial.\(^{55}\)

2.68 Dr Michael Mansfield argued that the focus of AHPRA's processes is 'punitive rather than educational or rehabilitative', and that, where appropriate, face-to-face meetings or mediation may serve to resolve complaints less stressfully, more cheaply and more quickly:

Facilitated face-to-face meetings of accused and accuser would be very beneficial, with regard to reducing the complexity and cost of unnecessary investigations, and it would facilitate a speedy resolution of breach issues.\(^{56}\)

2.69 The Health Care Consumers' Association (HCCA) made a similar point from a patient's perspective, arguing that 'many consumers may want to make an informal comment rather than a formal complaint', but that the existing notifications system does not readily allow this. The HCCA therefore recommended that learning how to receive feedback should be a skill taught to all medical professionals.\(^{57}\)

2.70 The HCCA notes a key problem is that medical complaints processes serve dual roles, one in relation to the practitioner and one in relation to the consumer, with the result that neither role is fully met:

Medical complaints processes aim to discipline and regulate professionals and deliver fair process, while also responding to consumer concerns. In reality, complaints processes are often not 'fit for purpose' for these disparate aims and as a result fail to achieve either disciplinary/regulatory or consumer outcomes.\(^{58}\)

2.71 To resolve this dichotomy, the HCCA recommended that the notifications process have a stronger patient focus in how it closes complaints, separate to any action that the National Board might take:

The complaints handling system should be changed to ensure that a consumer who is seeking an apology, further information or a fair hearing has access to a process that can deliver these outcomes; regardless of

\(^{55}\) Australian and New Zealand College of Anaesthetists, *Submission 5*, p. [3].

\(^{56}\) Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.


whether or not the issue raised is also appropriately dealt with as a notification by AHPRA or by other complaints-handling bodies.\textsuperscript{59}

2.72 Asked about adopting a less adversarial, more conciliation-based approach to managing complaints, AHPRA argued that the National Law does not give them the scope to do so:

We have considered that question before and I think it is relevant to point out that AHPRA and the national boards are part of the overall complaints management system, and there is also in each state and territory a health complaints entity. The health complaints entities do have the capacity to mediate or conciliate on complaints.\textsuperscript{60}

2.73 Surgeon Professor Paddy Dewan, in discussing the 'adversarial, legalistic mechanisms' of formal complaints and investigation processes, noted that such systems could be improved by making medical professional staff welfare a performance criterion for organisations such as AHPRA and the Colleges.\textsuperscript{61}

\textit{Committee view}

2.74 The committee recognises that public safety is the most important consideration in managing complaints against medical practitioners. However, safety is not improved if the medical complaints process is viewed as unnecessarily adversarial or confronting for either the notifier or the practitioner. While recognising that AHPRA's capacity to respond to notifications is prescribed in the National Law, the committee is of the view that a less adversarial approach to managing notifications may lead to improved public safety and better outcomes for practitioners.

\textit{Conflict of interest}

2.75 Some confidential submitters claim AHPRA's processes do not consider possible conflicts of interest when determining who conducts the investigation or can be a witness. For example, one submitter claims that an AHPRA board member involved in the investigation was also a colleague, whilst another states that a complainant (a relative of a deceased patient) was permitted to join the investigative team of the relevant state or territory board (now AHPRA). Another submitter claims one of AHPRA's expert witnesses in their investigation had financial interests in an industry that would benefit from a particular outcome.

2.76 Asked about AHPRA's processes for dealing with potential conflicts of interest, chief executive officer Mr Martin Fletcher responded:

We have a number of arrangements. We have people on a panel who are available to do assessments. One of the benefits of being a national scheme is that we can go outside a state or territory if we need to get somebody who

\textsuperscript{59} Health Care Consumers' Association, \textit{Submission 16}, p. 16.

\textsuperscript{60} Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, \textit{Committee Hansard}, 1 November 2016, p. 67.

\textsuperscript{61} Professor Paddy Dewan, \textit{Submission 3}, p. [2].
is not directly involved with a particular practitioner. The other area where we use independent experts is getting expert opinions. Often that might require us to get somebody who has quite a specialised area of knowledge—on a medical subspecialty, for example. Again, we would often seek advice from the relevant professional college or medical college about an appropriate expert to source. When we do that we do not disclose the name of the person, but, obviously, once we are approaching an individual to do the assessment or provide the expert opinion we do disclose the name, because we then need to establish that there is no conflict of interest that may mean that they are unable to do what we need them to do.62

**Qualifications of investigators**

2.77 A related concern expressed by medical practitioners is that the AHPRA officers who conduct investigations are not necessarily medically trained or qualified themselves, and therefore may lack understanding or appreciation of the medical situation involved.

2.78 This argument was summarised by Dr Michael Mansfield:

> The main problem, however, is that AHPRA—via its allowed misuse of mandatory reporting guidelines—is facilitating bullying [sic] on a level never before seen. This is because the investigators lack any medical expertise. They do not have the necessary perspective to judge serious versus vexatious claims, nor do they have the expertise to judge the merit of differing independent medical reports.63

2.79 Similarly, Dr Gary Fettke argued that AHPRA's 'flawed investigation process' is a consequence of investigators who are 'inadequately trained, supervised and audited'.64 Dr Fettke went on to note that, while decisions are made by the medical boards – whose members do have medical understanding – not all the information collected during an investigation necessarily forms part of the advice to the board:

> I have asked for all of my material to be put to the board and have it all reviewed by the board, but that does not happen. It is only very select. So the gatekeepers in our investigations are the investigators not the Medical Board.65

2.80 Dr Don Kane of HPARA likewise argued that inexperienced or unqualified investigators are producing reports that are inaccurate or fail to take into account the complexity of medical practice:

> The impression I get is that they [AHPRA investigators] are not well qualified to be in the positions they are in, and the use of sham peer review

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62 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 22 November 2016, p. 10.

63 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.


65 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 16.
both by AHPRA and by people who lodge complaints to AHPRA, be they
administrations or individuals, is quite a common practice, and it is very,
very damaging. They do not seem to have the expertise to realise that a
health service, whether it be in medicine, nursing or otherwise, is very
complex, and if you have reviews done by people who are not actually
expert in the work of the person that they are reviewing, you are very likely
to get a review that is not as it should be, and AHPRA does not seem to
have the wherewithal to recognise that.66

2.81 In response to these concerns, AHPRA outlined the backgrounds and
qualifications of their investigators and emphasised that, for the past two years, a
national standard training course had been delivered to all investigators:

Across the national scheme we employ probably around 100 investigators.
They come from a variety of backgrounds. When we are recruiting we are
particularly looking for people who have the skills to gather information
around a complaint, synthesise that information and write reports for the
information of the boards, who are the decision makers in the matter. They
come from a variety of backgrounds. Some of our investigators have
clinical backgrounds; others have experience working with other regulatory
agencies, with ombudsman's organisations and some have backgrounds
from the police service.

In terms of qualifications or credentialing, we have for the last two years
been delivering a standard training program to all of our investigators based
on the national certified investigator training program from the Council on
Licensure, Enforcement and Regulation. That program has been running for
more than 30 years and has trained over 19 000 investigators. We deliver
that now as baseline training for all of our investigators.67

2.82 AHPRA also clarified that, while board members are presented with a report
compiled by the investigator, they are also provided with a list of all other information
received during the investigation and can ask for any of that material.68

Caution made appealable

2.83 As outlined above, a National Board can caution a practitioner following
assessment of a notification. A caution, AHPRA notes:

… is like a written warning and is intended to act as a deterrent so that the
practitioner does not repeat the conduct or behaviour.

66 Dr Don Kane, Chair, Health Professionals Australia Reform Association, Committee Hansard,
1 November 2016, p. 37.

67 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory
Operations, Australian Health Practitioner Regulation Agency, Committee Hansard,
1 November 2016, p. 54.

68 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory
Operations, Australian Health Practitioner Regulation Agency, Committee Hansard,
1 November 2016, p. 55.
A caution is not usually recorded on the public register but may be published on the national register of practitioners if the National Board considers it appropriate to do so.\(^6\)

2.84 The Ombudsman, Ms Samantha Gavel, described a caution as 'the least action that AHPRA can take'.\(^7\)

2.85 Ms Kym Ayscough of AHPRA noted that:

> Under the national law, the board has available to it a number of regulatory responses. They really are considered to be in an escalating scale of seriousness, to respond to the different levels of regulatory risk, and a caution is a response that is at the very low end of the regulatory response.\(^8\)

2.86 While describing cautions as the 'low end' of possible responses, Ms Ayscough did confirm that all responses to notifications against a practitioner, including cautions, go to their employer.\(^9\)

2.87 Several submitters and witnesses noted that cautions issued by the National Boards are, unlike every other action available to Boards, not subject to administrative appeal, although there is the option of judicial review. The committee heard that the process could be improved by amending the National Law in relation to cautions.

2.88 Dr Joanna Flynn of the Medical Board of Australia noted that, while practitioners cannot appeal the decision to caution them, they are able to put forward their case before the caution is issued:

> A caution is not imposed unless a practitioner has been given notice of the board's intention to impose a caution and given an opportunity to make a submission in relation to it. So the practitioner does have an opportunity to make a submission, but that is not the same as an appeal; I accept that.\(^{10}\)

2.89 The argument for making cautions appealable was made by Dr Kerry Breen, who argued that the National Law is flawed in allowing Boards to issue a caution 'without the doctor being interviewed by a Board member or even by an AHPRA staff member'. Furthermore, Dr Breen argued:

> … under Section 199, such a caution is not open to appeal, contrary to all other Board decisions which universally are open to appeal. Section 206 of

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\(^7\) Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 10.

\(^8\) Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 64.

\(^9\) Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 64.

\(^10\) Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 65.
the legislation provides that any employer must be informed of the caution, thereby making the caution public and hence not a minor matter. Cautions of this type probably serve a useful purpose but there must be a mechanism for appeal.74

Committee view

2.90 The committee notes that, while a caution is the lowest level of action a Board can take in response to a complaint against a practitioner, that caution can affect a practitioner's career. As such, further consideration should be given to the option of allowing administrative review for cautions.

Recognition that bullying and harassment is a patient safety issue

2.91 A point made by some submitters to this inquiry was that bullying and harassment could be more effectively responded to if there was a greater recognition that these behaviours in the medical profession can affect patient safety. Submitters expressed concern that, as bullying and harassment is rarely seen as a patient safety issue, AHPRA has limited capacity to deal with complaints about these behaviours.

2.92 As an example, Mr John Ilott of the Australian and New Zealand College of Anaesthetists noted that issues with bullying and harassment are dealt with differently in New Zealand than they are in Australia:

I think one of the things that we have noticed in the difference between the Medical Council of New Zealand and the Medical Board of Australia is that the Medical Council of New Zealand is more prepared to acknowledge that bullying discrimination is likely to constitute a patient safety issue.75

2.93 The HCCA discussed this issue from the patients' point of view, noting that recent research demonstrates that bullying and harassment has an impact beyond that of the direct recipient of it:

There is now increasingly clear evidence that medical workplaces in which bullying and harassment are tolerated are unsafe for patients. The Joint Commission, an independent, not-for-profit organisation that accredits and certifies around 20,000 health care organisations and programs in the United States, reviewed behaviours that undermine a culture of safety and bullying and concluded that harassment featured prominently:

"Intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety,

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74 Dr Kerry Breen, Submission 103, p. 3.
75 Mr John Ilott, Chief Executive Officer, Australian and New Zealand College of Anaesthetists, Committee Hansard, 1 November 2016, p. 46.
health care organizations must address the problem of behaviours that threaten the performance of the health care team.”

Committee view

2.94 The committee is concerned that bullying and harassment, identified as a prevalent issue in the medical profession, is not currently considered to have a substantial impact on patient safety. The committee is of the view that the entire medical profession needs to, as a matter of priority, recognise this significant impact and AHPRA should take it into account when investigating notifications against practitioners.

Vexatious complaints and a declaration of good faith

2.95 One of the terms of reference for this inquiry suggested, as a possible solution to concerns about the vexatious use of complaints against practitioners, that notifiers could be obliged to sign a declaration of good faith. On the whole, while all submitters agreed that the making of vexatious or frivolous complaints was an unacceptable practice and unfortunate consequence of the complaints process, there was limited support for the notion of requiring notifiers to make a declaration of good faith. This primarily rested on two arguments: that those intent on making a vexatious complaint as a way of harassing or bullying a medical practitioner would be unlikely to be concerned by this requirement, and that some people with genuine complaints to make might be deterred by this additional requirement.

2.96 For example, AHPRA's Community Reference Group argued:

… it should also be considered that many complainants may wonder whether it is worth the personal and reputational risk to report a bad experience of healthcare, and that any requirement for complainants to sign a declaration 'that their complaint is being made in good faith' may not deter vexatious complainants, but may deter genuine complainants.

2.97 The Australian Nursing and Midwifery Federation (ANMF) also argued against this requirement, referring both to the unlikelihood of it deterring those intent on making a complaint for a vexatious reason and the probability that genuine complaints would be affected:

Such a declaration would unlikely prevent unnecessary notifications being made, however, it has the potential to serve as a deterrent to practitioners who are making a valid complaint for fear that it could be determined 'vexatious' and that they may suffer some kind of professional retribution if the complaint is not proven. Therefore, the ANMF does not support the introduction of a requirement for a declaration to be made.

76 Health Care Consumers' Association, Submission 16, p. 11.
77 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 25.
78 Australian Nursing and Midwifery Federation, Submission 99, p. 5.
2.98 Similarly, the Ombudsman argued that the inclusion of such a provision would be unlikely to prevent the lodging of vexatious complaints:

… requiring that people who lodge a notification sign a declaration that they are acting in good faith is not likely to reduce the number of notifications made or the incidence of possibly vexatious notifications. 79

2.99 The AMA was also against the inclusion of this requirement, arguing that since a majority of notifications are made by other health practitioners, the introduction of such a requirement would be 'effectively challenging the professionalism of these people'. 80 Further, the AMA argued, it would be unlikely to improve the process in any other way:

Given the relative transparency of the notifications process the AMA questions how the inclusion of this requirement would improve the information available to AHPRA in making its assessment or have any material impact on the result. 81

2.100 RANZCP also noted the possible effects of this step in deterring genuine complainants, while noting that the National Law includes a provision for the protection of complainants from civil, criminal and administrative liability if their complaint is made in good faith:

A potential complainant – whether patient or health practitioner – may already be anxious about lodging a complaint with AHPRA in addition to feeling detrimentally affected or aggravated by the behaviour they are seeking to complain about. Therefore, requiring complainants to take an additional step of having to sign a declaration that their complaint is being made in good faith may make complainants feel that their integrity or honesty is being questioned and, in fact, deter them from ultimately making a complaint to AHPRA. 82

2.101 Likewise, the HCCA argued that such a requirement would constitute a significant barrier for consumers, already suffering a power imbalance when dealing with the health system and individual practitioners, should they want to make a complaint:

The focus of policy and practice change in relation to medical complaints should be to reduce barriers to consumer complaints, and to support both complaints and feedback as opportunities for healthcare improvement. Introducing a requirement to sign a declaration would constitute a significant additional barrier to complaints-making and as a result should not be considered. 83

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79 National Health Practitioner Ombudsman and Privacy Commissioner, Submission 12, p. 4.
80 Australian Medical Association, Submission 9, p. 5.
81 Australian Medical Association, Submission 9, p. 6.
82 Royal Australian and New Zealand College of Psychiatrists, Submission 19, p. 5.
83 Health Care Consumers' Association, Submission 16, p. 18.
2.102 There were exceptions, however, to this broad agreement. The main argument for the inclusion of a requirement of a declaration of good faith was that vexatious complaints can have a major and detrimental effect on a practitioner's career and life, and therefore every effort should be made to minimise their incidence.

2.103 The ACEM noted that all complaints have an effect on the practitioner, even those which are later deemed to have been made vexatiously:

Complaints can be particularly damaging for those who have been cleared of the complaint made against them, since the allegations have previously been made visible on the AHPRA website during the complaints process. ACEM therefore considers it vital that complainants or notifiers sign a declaration that their complaint is being made in good faith, acknowledging the psychological, financial and career-related impacts that their complaint could have upon the individual.84

2.104 The ADA agreed that a 'good faith' declaration requirement may not dissuade potential vexatious complaints, and argued that instead 'it may be appropriate for complainants to have to make a payment when they lodge a complaint', or alternatively, requiring that vexatious complainants should be penalised.85

2.105 This latter position was echoed by other submitters, who – whether or not they supported the idea of a mandatory declaration of good faith – argued that those found to have made false complaints should be subject to prosecution or other penalties.

2.106 Professor John Stokes suggested an alternative approach. Instead of requiring complainants to sign a declaration or introducing a cost barrier, the proportion of vexatious complaints from fellow practitioners could be reduced by including an undertaking in the professional codes of conduct:

I think it would be important to overcome the objection to signing by putting a statement into the salient code of conduct for medical practitioners, in both section 4 and section 8 of those documents. Section 4 concerns working with other health professionals and section 8 is on professional behaviour. So a simple statement in there that it is part of professional behaviour not to make vexatious complaints would make it unnecessary for a mandatory notification. The guidelines from AHPRA are extremely loose. You could drive a truck through them. Such a statement would stop that.86

2.107 A similar suggestion was made by some confidential submitters, who argued that independent Code of Conduct committees would be an appropriate way of handling all forms of bullying and harassment.

2.108 Strengthening the codes of conduct for the various specialities within the medical profession could therefore take the form of not just discouraging bullying and

84 Australasian College of Emergency Medicine, Submission 4, p. 4.
85 Australian Dental Association, Submission 6, p. [5].
86 Professor John Stokes, Committee Hansard, 1 November 2016, p. 13.
harassment, but specifically prohibiting the vexatious lodgement of notifications against colleagues.

Committee view

2.109 The committee is concerned that there are not currently sufficient deterrents against practitioners lodging a complaint for vexatious reasons and for that reason agrees that professional codes of conduct should be strengthened in this regard. Further, the committee agrees that imposing penalties upon those found to have made vexatious complaints would be a further deterrent to this form of bullying and harassment.

Benchmarking

2.110 'Benchmarking' refers to the practice of comparing complication rates for a particular procedure across practitioners. The complication rate of an individual practitioner can then be compared to that of other similarly qualified practitioners as part of an investigation or audit.  

2.111 AHPRA confirmed that benchmarking of complication rates may occur as part of an investigation:

Analysis of complication rates and benchmarking (including as part of a performance assessment) may assist the MBA and/or its delegates to make an informed judgement as to the level of risk posed by the practice of the medical practitioner and appropriate actions to be taken by the MBA.

Benchmarking is a complex undertaking that must consider factors such as the speciality of the field of medical practice and the patient cohort involved. It is, therefore, important to note that where benchmarking is undertaken, AHPRA seeks the opinion of an independent expert and does not undertake its own benchmarking.  

2.112 Some confidential submitters support benchmarking on the basis, as discussed above, that the investigative teams lack the medical knowledge to make educated judgements. Other confidential submitters voice concern that accurate benchmarking is difficult to determine and suggest it should only be used when it will improve outcomes.

2.113 While arguing that more data and reporting would be useful, the HCCA noted that there is a 'fundamental problem' with increased benchmarking:

… the paucity of relevant and useful data in most areas of medicine upon which to base this kind of benchmarking data. While there are specialised registries in a limited number of areas, for example joint prostheses and

87 See: Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 10.

88 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, Submission 21, p. 10.
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neo-natal intensive care, the capacity to produce benchmarks that are clinically meaningful across healthcare is at present very limited.89

2.114 The ACEM also noted that figures are not currently comprehensive enough for benchmarking to be meaningful.90

2.115 The AMA argued that a potential disadvantage of increased use of benchmarking might be to influence how practitioners treat patients, with an over-emphasis on concerns about benchmarking data:

Benchmarking can be complex and lead to perverse outcomes such as providing a disincentive for doctors to try new treatments, or self-protective practices such as not performing higher risk procedures because of the potential effect on outcome measures.91

2.116 ANZCA also expressed concerns with the use of outcome data to benchmark complication rates, and made several points against the practice. ANZCA argued that the data at an individual level misrepresents the team-based nature of much of medical practice; may contribute to competitiveness and a lack of support between colleagues if they are overly concerned with individualised benchmarking data; and further often lacks the context necessary, since no two patients have identical experiences either before or after the medical intervention.92

2.117 The ADA made a similar point regarding the variability of procedures and the complexity that creates in benchmarking data:

For example, any benchmarking of outcomes, regardless of the 'sameness' of the procedure, will need to consider the impact of practitioner ability and care as much as:

- how easy or difficult the patient is to treat (behavioural concerns);
- the complexity of the presentation case despite the procedure. It is often the case for example that specialists do more complicated cases, but the procedure is still classified the same;
- the patient's particular medical history;
- compliance with post-operative instructions on the part of the patient/family/carer;
- compliance with post-operative instructions on the part of the health care facility (for in-patient procedures); and
- the general quality of assistance available to the operator and patient at the time of the procedure and thereafter.93

89 Health Care Consumers' Association, Submission 16, p. 17.
90 Australasian College of Emergency Medicine, Submission 4, p. 4.
91 Australian Medical Association, Submission 9, p. 5.
92 Australian and New Zealand College of Anaesthetists, Submission 5, pp [4–5].
93 Australian Dental Association, Submission 6, p. [4].
Professional and personal consequences of investigations

2.118 Submitters note significant professional consequences from being investigated, where even minor findings against them have left a permanent mark on their record, affecting their employability. Submitters discussed the difficulty in applying for positions when it is standard practice to ask if the applicant has received a notification from AHPRA and noted that their employability has been negatively impacted by having an official record for 'trivial matters'.

2.119 Almost all confidential submitters who have been investigated by AHPRA discussed the personal toll of the stress incurred as a result of the investigations.

2.120 Professor John Stokes expanded on this and discussed the toll that being the subject of a vexatious complaint and subsequent AHPRA investigation can have on practitioners:

Many practitioners are dissatisfied with the mechanism. That is because of the significant unintended consequences of vexatious reporting, which causes practitioner illness. It also causes severe financial hardship and, in a number of cases that we know about, has caused the suicide of very good doctors.94

2.121 Dr Gary Fettke also emphasised the wide-ranging effects of having a complaint made against him and an investigation launched:

It has changed me as a person. I think we all go into medicine for all the right reasons: to try and make a difference. When you try and make that difference and you are hammered not only by your institution but then in the wider community, it changes you. I am more defensive about what I say to my patients. When you are under investigation, particularly for a vexatious claim, you think, 'Actually, I've done nothing wrong here; I'm helping people.' It becomes all-consuming. You lose sleep. My wife and I spend hours beyond normal work hours trying to sort this out. It has affected our children with a combination of anxiety, depression and becoming more introverted. What should be a pleasant experience of helping people is now something you question every day: 'Why do I keep doing this'?95

Committee view

2.122 The committee notes the large number of personal accounts it received from, or on behalf of, medical practitioners whose lives and careers had suffered as a consequence of a complaint made against them. Patient safety and an open medical complaints process cannot be compromised, and the committee is deeply concerned by the evidence it has received which suggests that these may have been misused for the sake of bullying and harassing medical practitioners.

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94 Professor John Stokes, Committee Hansard, 1 November 2016, p. 13.
95 Dr Gary Fettke, Committee Hansard, 1 November 2016, p. 21.
**Conclusion and committee view**

2.123 Patient safety is of paramount importance in the medical profession, and for that reason it is vital that all Australians can trust that concerns about individual practitioners are taken seriously. As such, supporting a robust medical complaints system that takes appropriate action to ensure public safety is a central responsibility of the body created to administer the National Registration and Accreditation Scheme.

2.124 Equally, however, it is important that the process is trusted by medical practitioners themselves and is used only for its purpose of protecting public safety. It is clear that in this regard, Australia's medical complaints process does not have the complete confidence of sections of Australia's medical profession. As this committee has heard, AHPRA's notification and investigation process is vulnerable to misuse by individuals. Medical professionals have identified that lodging a notification against a colleague or competitor can serve as a tool of bullying and harassment.

2.125 While it is difficult to establish the prevalence of this practice, and noting the statistics on notifications which suggest it is relatively rare, the committee is nonetheless deeply concerned about this form of bullying and harassment. As many of the medical practitioners who made submissions to this inquiry noted, the toll on any individual can be very high. Furthermore, concerns which undermine any aspect of Australia's medical complaints process will have a negative effect on the integrity of the entire system and can serve to decrease public safety.

2.126 The committee has also received evidence that, in addition to the possibility of using the medical complaints process as a tool of bullying and harassment, other concerns with the complaints process exist. These concerns are explored in chapter 4.
Chapter 3

Bullying and harassment in the medical profession

3.1 While the focus of this inquiry was on the use of the medical complaints process as a tool of bullying and harassment within the medical profession, the committee also received a large number of submissions outlining broader concerns with the prevalence of bullying and harassment in Australia's medical profession. As discussed in the first chapter, this level of bullying and harassment presents a considerable risk to members of the health care sector, but also to the Australian public as a whole, and for that reason the committee is concerned by the evidence it has received.

3.2 This chapter discusses not just the prevalence and forms of bullying and harassment evident in the medical profession, but the real and perceived barriers to reporting these behaviours. It also examines responses to address bullying and harassment from the medical sector, including medical boards, government, colleges and hospitals. These responses emphasise the need for a cross-sector, coordinated approach to addressing these issues.

Prevalence of bullying and harassment

3.3 In their submissions to this inquiry, medical administrators and colleges emphasised that they take a 'zero-tolerance' approach to all forms of bullying and harassment. However, as recent research has demonstrated, and as was further illustrated by evidence submitted to this inquiry, bullying and harassment remains prevalent within the medical profession.

3.4 Within the profession itself, there is general recognition that bullying and harassment is a significant problem. For example, the AMA acknowledges that recent reports indicate:

… the hierarchical nature of medicine, gender and cultural stereotypes, power imbalance inherent in medical training, and the competitive nature of practice and training has engendered a culture of bullying and harassment that has, over time, become pervasive and institutionalised in some areas of medicine.

3.5 Mr John Biviano of the Royal Australasian College of Surgeons (RACS) made a similar point:

[References]

1 See, for example: Australasian College for Emergency Medicine, Submission 4, p. 1; Australian and New Zealand College of Anaesthetists, Submission 5, p. 2; Royal Australasian College of Medical Administrators, Submission 18, pp 1–2; Royal Australian and New Zealand College of Psychiatrists, Submission 19, p. 1; Royal Australian and New Zealand College of Radiologists, Submission 20, p. 1.

2 Australian Medical Association (AMA), Submission 9, p. 1.
The college, or RACS as it is typically known, acknowledges that there is no doubt that bullying and harassment occurs in the surgical workplace and takes very seriously the subject of this inquiry.\(^3\)

3.6 Dr Catherine Yelland of the Royal Australasian College of Physicians (RACP) concurred, noting that:

We regard bullying and harassment as unacceptable, and the college has no tolerance of these behaviours.

[…]

There is significant evidence in Australia and overseas that bullying and harassment are a problem across all healthcare professions. We can provide more detail if required. We regularly survey trainees, seeking feedback on the quality of their training, supervision and support. We may include questions on bullying and harassment in the future.\(^4\)

3.7 The Royal Australasian College of Medical Administrators' Professor Gavin Frost likewise expressed concern about the prevalence of bullying and harassment and reiterated the College's policies against such behaviours:

As with my colleagues, our college has zero tolerance for harassment and bullying of any kind and our policies and procedures clearly set that out.\(^5\)

3.8 The peak representative group for doctors, the Australian Medical Association, argued that:

… all doctors have the right to train and practice in a safe workplace free from bullying and harassment and [the AMA] holds a zero tolerance approach to all forms of bullying.\(^6\)

3.9 Despite the consensus that bullying and harassment is unacceptable, there is concern that the actual prevalence of such behaviour is unknown or underreported. The Australian Nursing and Midwifery Federation (ANMF), for instance, noted that it is difficult to quantify the prevalence of bullying and harassment in the nursing and midwifery profession due to a lack of national data. However, the ANMF referred to recent research and submissions from organisations within the nursing and midwifery profession that all indicated 'significant levels' of bullying and harassment.\(^7\)

3.10 The committee particularly notes the 2015 report by the Expert Advisory Group to the Royal Australasian College of Surgeons (RACS), which highlights the wide-reaching prevalence and negative impacts of bullying and harassment in the

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3 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 41.

4 Dr Catherine Yelland, President, Royal Australasian College of Physicians, *Committee Hansard*, 1 November 2016, p. 42, 43.

5 Professor Gavin Frost, Dean of Fellowship Education, Royal Australasian College of Medical Administrators, *Committee Hansard*, 1 November 2016, p. 43.


surgical profession. The key findings of this report are referenced throughout this chapter and summarised in Box 3.1.

**Box 3.1 – Royal Australasian College of Surgeons – Expert Advisory Group on discrimination, bullying and sexual harassment**

In March 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group to investigate the prevalence of discrimination, bullying and harassment within the surgical profession. The EAG consultations included over 3,500 participants including fellows, trainees and international medical graduates, as well as over 100 hospitals.

Key findings of the Expert Advisory Group's final report to RACS include:

- **49 per cent** of fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment;
- **54 per cent** of trainees and **45 per cent** of fellows less than 10 years post-fellowship report being subjected to bullying;
- **71 per cent** of hospitals reported discrimination, bullying or sexual harassment in their hospital in the last five years, with bullying the most frequently reported issue;
- **39 per cent** of fellows, trainees and international medical graduates report bullying, **18 per cent** report discrimination, **19 per cent** report workplace harassment and **7 per cent** sexual harassment;
- the problems exist across all surgical specialties; and
- senior surgeons and surgical consultants are reported as the primary source of these problems.


**Definitions**

3.11 For the purpose of this inquiry, the committee refers to bullying and harassment as defined by the RACS Expert Advisory Group. Box 3.2 outlines these key definitions.

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Box 3.2 – Definitions of bullying and harassment

**Bullying**
Bullying is unreasonable and inappropriate behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. Such behaviour intimidates, offends, degrades, insults or humiliates. It can include psychological, social, and physical bullying.

**Harassment**
Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can include racial hatred and vilification, be related to a disability, or the victimisation of a person who has made a complaint.


3.12 Anecdotal evidence from submitters and witnesses to this inquiry supports the findings of the Expert Advisory Group report that bullying and harassment is a significant problem in the medical profession, across a range of specialities.

3.13 In many instances, this can be seen as a cultural problem within the profession; the committee notes considerable evidence suggesting that particular groups – including medical students and junior doctors, women and doctors of Indigenous or non-English speaking backgrounds – are more likely to be the subject of bullying and harassment.

3.14 Examples of the different types of bullying and harassment raised by submitters and witnesses are outlined below.

**Medical and nursing students and trainees**

3.15 The committee heard that many medical and nursing students and trainees experience a particular form of bullying and harassment during training. Submitters described either being a trainee or observing a trainee being bullied and harassed during clinical placements. In some instances, this resulted in the trainee either:

- being failed in assessments;
- transferring mid-placement to another hospital and thus delaying completion of their placement; or
- quitting their specialist training programs.

3.16 The Australian Medical Students' Association (AMSA) noted that bullying and harassment is widespread in medical education and includes 'teaching by humiliation' as well as 'derogatory remarks, inappropriate humour, ignoring students and setting impossible tasks or deadlines'.

9 Australian Medical Students' Association (AMSA), *Submission 10*, p. 2.
AMSA drew the committee's attention to a recent study of medical students in Sydney and Melbourne published in the *Medical Journal of Australia* that indicated that 74.0 per cent of medical students had experienced teaching by humiliation, and 83.6 per cent had witnessed it.  

Some confidential submitters to this inquiry particularly noted that, as trainees or junior doctors, they had particular concerns about making a complaint about this bullying since it would have a negative impact on their future career. This issue will be further discussed below as a barrier to reporting bullying and harassment.

**Sexual harassment and discrimination**

The committee is concerned by the reported prevalence of sexual harassment in the medical profession, perpetrated particularly against female doctors, students and trainees. **Box 3.3** outlines the definition of sexual harassment defined by RACS.

**Box 3.3 – Sexual harassment**

Sexual harassment is defined as unwelcome sexual advances, request for sexual favours and other unwelcome conduct of a sexual nature, by which a reasonable person would be offended, humiliated or intimidated. Sexual harassment may include, but is not limited to: leering; displays of sexually suggestive pictures, videos, audio tapes, emails & blogs, etc., books or objects; sexual innuendo; sexually explicit or offensive jokes; graphic verbal commentaries about an individual’s body; sexually degrading words used to describe an individual; pressure for sexual activity; persistent requests for dates; intrusive remarks, questions or insinuations about a person’s sexual or private life; unwelcome sexual flirtations, advances or propositions; and unwelcome touching of an individual, molestation or physical violence such as rape.


Miss Elise Buisson, President of AMSA, described to the committee one example of sexual harassment experienced by female medical trainees:

...a student reported to me that they were sitting in surgical grand rounds, so that is when all the surgeons in the hospital come together and have an educational meeting. Someone presents some research to them. A trainee doctor stood up, gave an absolutely outstanding presentation—they had put a lot of work into it—and a quite established male surgeon was very loudly interrupting her as she went on, saying, 'My, my, my! Haven't they let you out of the kitchen a lot this month!' and various other statements about her being female … He laughed, and everyone laughed, and the head of surgery at a medical school in that city was sitting in the room and did nothing, as did everybody else.  

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AMSA drew the committee's attention to a recent survey by the Australian Medical Association Western Australia which found that sexual harassment is 'endemic' across WA Health and Medicine. The survey found that 31 per cent of the 950 respondents had experienced sexual harassment in the workplace, including whilst applying for a job or training program. Of those reporting sexual harassment, 81 per cent were women.  

**Racial discrimination**

Alongside sexual harassment and discrimination, recent reports have suggested that racial discrimination remains a problem in the medical profession.

The committee heard that Aboriginal and Torres Strait Islander doctors and students experience racial discrimination as part of their training and practice.

The Australian Indigenous Doctors' Association (AIDA) told the committee that results of a recent survey, *Bullying, Racism and Lateral Violence in the workplace*, indicated almost all members reported having witnessed bullying in their workplace, and over half reported having witnessed racism at least once a week. Examples of racism included:

… doubting members' status as Aboriginal and Torres Strait Islander, experiences of 'unrelenting and systematic bullying', being belittled and shamed, and verbal racist abuse'.

AIDA submitted that bullying and harassment 'often in the form of racist remarks or behaviour', together with inadequate reporting mechanisms:

… create a culturally unsafe work environment, lacking in respect and support, and create a barrier for Indigenous medical students and doctors to pursue and persist on their medical career.

The Expert Advisory Group final report to RACS found that 27 per cent of international medical graduates reported either racial or sexual discrimination.

In its 2012 inquiry into registration processes and support for overseas trained doctors, the House of Representatives Standing Committee on Health and Ageing heard that international medical graduates reported bullying and harassment as they...
worked through accreditation and registration. Its final report, *Lost in the Labyrinth*, recommended that:

… the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its Guidelines – *Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies.

3.28 As of November 2016, the government had not responded to this report.

3.29 While it was not a major theme of this inquiry, several confidential submitters noted their own experiences of race-based bullying and harassment.

**Media and social media**

3.30 Following on from the use of the medical complaints process as a tool of bullying and harassment, as discussed in the previous chapter, some submitters noted that they had been subject to a further level of bullying and harassment when the details of complaints made against them were given to the media, or disseminated via social media.

3.31 Submitters state in these instances, the media often report false allegations, doing irreparable damage to their reputation. Others claim they have been cyberbullied through social media.

3.32 For example, Dr Gary Fettke explained to the committee that during his investigation by AHPRA, he became aware that the person who lodged the notification against him had also been posting what he characterised as 'defamatory material on a social media hate site'.

**Patients and families**

3.33 The committee received a small number of submissions from patients or their families who reported that they had been bullied and harassed by medical professionals. Most of these submitters have made complaints to AHPRA and were unsatisfied with AHPRA's response.

3.34 Submitters expressed concern that bullying and harassment between medical practitioners may impact on patients. For example, the Health Care Consumers Association expressed concern that:


20 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 19.
...a culture that accepts and condones bullying is not conducive to good patient care and must be addressed. Further, where a culture condones bullying in the staff, there is evidence that this can reduce empathy towards patients and can lead [sic] to disrespect and bullying of patients.\textsuperscript{21}  

3.35 Several confidential submitters argued that the lack of focus on bullying's impact on patient safety means that there is not appropriate recognition of the problem or clear lines for patients and members of the public to report bullying and harassment by medical practitioners. These submitters expressed concern that their complaints were not taken seriously.  

3.36 Some confidential submitters noted that questioning any aspect of their treatment resulted in bullying and harassment and in some cases this affected their ability to receive further treatment. Conversely, other patients discussed their problems receiving treatment because their doctor had their practice restricted because of a vexatious complaint.  

\section*{Committee view}  

3.37 The committee expresses deep concern about the reported prevalence of bullying and harassment in the medical profession and reiterates that bullying and harassment in any workplace is unacceptable and must not be tolerated.  

3.38 The committee notes that evidence from submissions supports recent research that highlights the prevalence of bullying and harassment across different specialities.  

3.39 The committee recognises that bullying and harassment in the medical profession pose threats to public safety and patient wellbeing, and for that additional reason is particularly concerned by the prevalence of bullying and harassment in the medical profession.  

\section*{Barriers to reporting bullying and harassment}  

3.40 Submitters and witnesses identified two key barriers to reporting bullying and harassment in the medical profession related to:  

- lack of clarity and trust in the reporting process; and  
- cultural issues within the medical profession.  

\subsection*{Process issues}  

\subsubsection*{Clarity of existing reporting mechanisms}  

3.41 The committee heard that there is a lack of clarity and awareness in the medical profession of the appropriate mechanisms for reporting bullying and harassment. Submitters highlighted that processes for making complaints, or for subsequently addressing complaints, are not well understood. For example, the AMA noted in its submission that a 2014 survey of specialist trainees found that general

\textsuperscript{21} Health Care Consumers Association, \textit{Submission 16}, p. 12.
awareness of bullying and harassment policies across all colleges is low, with only 30 per cent reporting that they are aware of these.22

3.42 The committee notes that confusion about the complaints process was one of key findings of the Expert Advisory Group in its report to RACS, particularly:

… with a lack of coordination or clarity about where to lodge a complaint or how to raise an issue (between the College, employers and, for students, universities), if one were brave enough to do so.23

3.43 Mr John Biviano from RACS told the committee the existing complaints mechanisms lack coordination across the sector:

… the oversight of health professions is complex and difficult to navigate. It involves medical colleges, health departments, hospitals and regulators, including the Medical Board of Australia and AHPRA. There is a clear lack of coordination between these bodies and fragmentation of the system.24

Trust in existing complaints processes

3.44 Submitters expressed a lack of trust in the complaints system's ability to produce a fair outcome, suggesting that this may discourage victims from reporting bullying and harassment. For example, AIDA's survey of its membership found that the majority of members:

… reported that policies and procedures were in place at their workplace but stated that they did not believe that victims or perpetrators were adequately supported by the existing policies and procedures, suggesting a lack of confidence, particularly in complaints procedures and the actual application of existing policies.25

3.45 Similarly, the Australian College of Emergency Medicine argued that:

… medical practitioners are less likely to make a report if they are not confident that the issue will be dealt with in a way that will bring about meaningful and positive outcomes, and/or if they believe that their day-to-day lives in the workplace will be impacted upon negatively as a result of making a report.26

3.46 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) also submitted that many workplaces that do not have appropriate processes for reporting bullying:

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22 AMA, Submission 9, p. 2.
24 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, Committee Hansard, 1 November 2016, p. 42.
25 Australian Indigenous Doctors' Association, Submission 8, p. 3.
26 Australasian College of Emergency Medicine, Submission 4, p. 1.
... a key question is how the relevant workplace deals with bullying and harassment claims and how it conducts and resolves investigations into these claims. If appropriate and supportive mechanisms are not in place, this represents a clear barrier to medical practitioners reporting bullying and harassment.27

3.47 The committee notes that the Expert Advisory Group to RACS also found:

... there is a lack of trust and confidence in the people handling complaints and the processes in place at the College and across the health sector. There is confusion about processes that are often legalistic and narrowly defined; and a demonstrable lack of consequences for perpetrators.28

3.48 Despite the recent media and public attention on bullying and harassment within the medical profession, the committee notes that awareness amongst practitioners of the existing policies and procedures is not high. While it is evident that some work has been done to improve this, it is clear that this remains a problem requiring the attention of medical colleges, workplaces and medical schools.

**Cultural issues**

3.49 The committee was particularly concerned by evidence that suggests that the culture of the medical profession does not support the reporting of bullying and harassment.

**Accepted culture of bullying**

3.50 Submitters and witnesses suggested that in some sections of the medical profession, bullying is accepted as part of the workplace culture. For example, beyondblue submitted that recent research indicates that there is some concern that:

... there may be a "culture" that allows bullying and harassment to occur within the medical profession, and that this may be a transgenerational phenomenon ingrained in the profession.29

3.51 The committee notes that submissions to this inquiry support the findings of the Expert Advisory Group's report to RACS which found that in relation to the surgical profession, 'bullying has become normalised as a culturally accepted behaviour' and issues of discrimination, bullying and sexual harassment are:

... enmeshed with questions about the culture of surgical practice, as well as the culture of medicine and the healthcare sector more widely.30

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27 RANCP, Submission 19, pp 1–2.


29 Beyondblue, Submission 11, p. 17.

3.52 The committee heard that the culture of bullying particularly affects medical students and trainees. AMSA highlighted that a recent study of mistreatment of medical students indicated that 50 per cent of students had come to believe that mistreatment is 'necessary and beneficial for learning'. Similar findings were reported by the Victorian Auditor-General, which noted a high degree of acceptance of bullying and harassment among junior doctors:

Such behaviour was explained as a 'training technique' that helped motivate them to work harder, or as unfortunate but an inevitable rite of passage and part of the 'old-school way'.

Fear of repercussions

3.53 One of the key barriers to reporting instances of bullying and harassment reported by submitters and witnesses was fear of negative repercussions from making a complaint. Many submitters were concerned that making a complaint against a senior colleague would adversely affect their future career. Others expressed a fear of reprisals against them for making a complaint at their workplace against a colleague. As discussed in chapter 2, confidential submitters who have suffered bullying or harassment are also concerned that the retaliation would take the form of a vexatious notification being lodged against them.

3.54 For example, Dr Artiene Tatian from AIDA told the committee that a survey of its members found that over half did not report bullying and harassment due to a fear of negative repercussions. Dr Ben Armstrong from AIDA also told the committee that for the 40 per cent of members who had initiated some sort of complaint reconciliation, the vast majority were ignored or not actioned and 'they often had negative repercussions, which discouraged them from making further complaints'.

3.55 The committee heard that fear of negative repercussions are particularly acute among students and trainees who are concerned about the impact of making a complaint on their career progression. Miss Elise Buisson from AMSA told the committee, that often students are advised not to make reports, due to possible negative impacts on their careers:

Even very well-meaning clinicians or faculty members will advise you not to report certain things: 'Look, it's probably not that bad. If you are to do it, it's going to have a really negative effect on your career.' And if someone


33 Dr Artiene Tatian, Board Director, AIDA, *Committee Hansard*, 1 November 2016, p. 33.

34 Dr Benjamin Armstrong, Board Director, AIDA, *Committee Hansard*, 1 November 2016, p. 33.
was to come to me and say, 'Should I report X', I would find it very difficult to know what is the best course of action for them.  

3.56 Similarly, the Royal Australasian College of Medical Administrators argued that concern for career progression is the paramount reason why complaints about bullying and harassment are often not lodged:

The key barrier for medical practitioners taking action is the belief that it will adversely affect future career options. This is supported by the survey undertaken by RACMA in 2015 on bullying, harassment and discrimination and consultations with RACMA’s membership. Additionally reasons cited are the perceived stress associated with filing a complaint and enduring an investigation, and the perception there is potential for victimisation as a result of raising the matter.  

_Silence of by-standers_  

3.57 The committee heard that the combination of process and cultural issues contributes to an environment where those by-standers who witness bullying and harassment are not supported to report the behaviour. The AMA submitted that there may be two different reasons why by-standers do not speak up when witnessing 'unacceptable behaviour', they may:

- not recognise the behaviour as discrimination, bullying or sexual harassment; or
- harbour distrust in the complaint mechanism – that the complaint will not be taken seriously, that someone else's word will be taken over theirs, that victimisation will ensue, or that it would ultimately not be in the best interests of the victim to raise it.  

3.58 The 'silence of by-standers' was identified by the Expert Advisory Group to RACS as a 'critical issue', which:

… stems from fear of reprisal, fear of 'making it worse', concerns about their position or right to raise an issue given hierarchical structures and power differences; prominent people are perpetrators, bullies are seen as untouchable.  

_Gender inequality and cultural diversity_  

3.59 The committee also heard that gender inequality presents barriers for reporting bullying and harassment, particularly for women. The AMA pointed out that:

Gender inequity has a proven causal relationship with the incidence of discrimination, bullying and sexual harassment of women. It is important

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35 Miss Elise Buisson, President, AMSA, *Committee Hansard*, 1 November 2016, p. 27.
37 AMA, *Submission 9*, p. 3.
that sexual harassment, discrimination and non-sexualised incivility is acknowledged as a manifestation of broader gender inequality.  

3.60 The Expert Advisory Group also highlighted that lack of cultural diversity, together with gender inequality, contribute to a workplace culture that does not support the reporting of bullying and harassment:

Gender inequity and limited cultural diversity also featured as both cause and effect in relation to culture. Both were seen to enable the continuation of the dominant surgical culture and were a consequence of it.  

**Addressing bullying and harassment**

3.61 Submitters and witnesses highlighted that addressing bullying and harassment in the medical profession will require a cross-sector approach, including government, medical boards, AHPRA, hospitals and speciality colleges. Some of the approaches to addressing bullying and harassment undertaken so far are outlined below.

**Medical boards and AHPRA**

3.62 Submitters highlighted that the formal medical complaints process administered by AHPRA and the Medical Board of Australia (MBA) and Nursing and Midwifery Board of Australia (NMBA) is just one mechanism for addressing bullying and harassment. As discussed in chapter 2, the key focus of the formal AHPRA complaints process is patient safety.

3.63 AHPRA, the MBA and the NMBA acknowledged that they have an important role to play in addressing bullying and harassment:

Bullying and harassment can be very damaging to the people who are subject to these behaviours and to the safety of patients. There is no place for these behaviours in the Australian medical, nursing, midwifery or registered health practitioner workforce. Through our role in the national regulation of health practitioners, we are committed to playing our part in supporting the health and well-being of medical practitioners, nurses and midwives and ending discrimination, bullying and harassment.

3.64 However, the MBA, NMBA and AHPRA emphasised that:

Not all allegations of bullying and harassment that involve medical practitioners, nurses or midwives are appropriate for action by the MBA or NMBA as the threshold for regulatory action may not be met.

3.65 Dr Joanna Flynn, Chair of the MBA, told the committee that in most cases, AHPRA and the boards are not the most appropriate place to address discrimination, bullying and harassment:

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42 MBA, NMBA and AHPRA, *Submission 21*, p. 4.
... the boards are not the appropriate first point of call for most matters in relation to bullying, which ought to be dealt with locally and investigated locally. Most problems should be solved close to the source of they can.43

3.66 Dr Flynn emphasised that:

While the Medical Board and Nursing and Midwifery Board and AHPRA have important roles to play, the medical complaints process and our regulation of health practitioners will not, on its own, address bullying and harassment and deliver the change in culture that we seek. That is why we work in partnership with the professions, employers, colleges, health departments and other health complaints bodies to help end bullying and harassment.44

3.67 Similarly, the ANMF commented that AHPRA:

... are unlikely to be able to deal with reporting of bullying in a useful manner, particularly in dealing with the underlying issues which are usually organisational, rather than individual. A report to AHPRA actually negates the occupational health and safety nature of bullying, and the need for a risk management approach to be implemented, as well as investigating the root cause of the issue.45

Codes of conduct

3.68 The MBA, NMBA and AHPRA noted that one of their key roles is to provide guidance on what is expected of registered practitioners through a code of conduct:

Such guidance sets out the principles that characterise good practice and makes explicit the standards of ethical and professional conduct expected by their professional peers and the community.46

3.69 The MBA pointed to its publication, Good Medical Practice: A Code of Conduct for Doctors, which was developed to guide doctors in their professional practice and roles, and set 'clear expectations on medical practitioners to act and communicate respectfully to both patients and colleagues'.47

3.70 The NMBA noted that the Codes of Professional Conduct for midwives and nurses is currently under review, and expects to conduct a public consultation on the revised codes in early 2017.48

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43 Dr Joanna Flynn, Chair, Medical Board of Australia, Committee Hansard, 1 November 2016, p. 61.
44 Dr Joanna Flynn, Chair, Medical Board of Australia, Committee Hansard, 1 November 2016, p. 53.
45 ANMF, Submission 99, p. 3.
46 MBA, NMBA and AHPRA, Submission 21, p. 3.
47 MBA, NMBA and AHPRA, Submission 21, p. 3.
48 The NMBA notes that its analysis of notifications made between 2010 and 2015 identified that 'aggression' and 'bullying' were two of the largest categories of notifications. A focus of the review process is 'ensuring that the revised codes address these issues and set clear requirements for expected behaviours'. See: MBA, NMBA and AHPRA, Submission 21, p. 3.
3.71 Some submitters suggested that one way that AHPRA and the boards could assist in addressing bullying and harassment is through the codes of conduct they administer. The Australian Dental Association (ADA) recommended that the Code of Conduct for registered health professionals 'should be strengthened to reinforce the overall duty of care of health professionals, particularly those in employer positions, to ensure the safety of their colleagues, staff and patients.'

3.72 Beyondblue recommended that responses to bullying and harassment levels should be part of a broader focus on mental health, recognising the substantial impact on mental health that workplace bullying and harassment have. Beyondblue suggested that action on bullying and harassment should be based on a culture of 'respectful relationships' and recommended that reference to 'respectful relationships' be incorporated in the code of conduct administered by the MBA and those of the individual colleges.

3.73 The Australian Indigenous Doctors' Association recommended that a key measure to reduce the levels of bullying and harassment in the medical profession would be to mandate cultural safety training for all employees in the health sector.

**Speciality colleges**

3.74 Following the release of the Expert Advisory Group's report to RACS in 2015, the committee heard that all speciality colleges have undertaken reviews of their reporting and complaints mechanisms. The Committee of Presidents of Medical Colleges stated that:

> All specialist Medical Colleges are fully committed to fulfilling their obligations to eliminate or minimise the risk of bullying. Each has undertaken a system review to ensure appropriate policies and procedures are in place to manage complaints relating to bullying, which also includes regular compliance checks to ensure policies and procedures are up-to-date and staff are provided with information and training.

3.75 In particular, the committee heard that RACS has dedicated 'enormous resources' to responding to the Expert Advisory Group report through its November 2015 action plan, *Building respect, improving patient safety*. Mr John Biviano from RACS told the committee that the key actions taken by RACS to date as part of the action plan include:

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50 Beyondblue, *Submission 11*, p. 3.
52 Committee of Presidents of Medical Colleges, *Submission 14*, p. 1.
• working with health departments and hospitals to develop strategies to address
discrimination, bullying and sexual harassment, including developing
memorandums of understanding between RACS and hospitals;\textsuperscript{54}
• introducing mandated courses for surgeons involved in education on 'basic adult education principles', building awareness of discrimination, bullying and harassment, and skills for supervisors; and
• devoting more resources to complaints management, including a centralised database and process to resolve complaints.\textsuperscript{55}

3.76 The committee heard that while RACS is leading the colleges in addressing these issues, other colleges are also seeking to address bullying and harassment. The Committee of Presidents of Medical Colleges (CPMC) noted that:

… all specialist Medical Colleges have subsequently undertaken assessment processes to recommend actions their individual College could take directly and in partnership with hospitals and employers to mitigate and prevent such behaviours from occurring.\textsuperscript{56}

3.77 A number of colleges made submissions to the inquiry outlining the specific measures they have taken to address bullying and harassment. For example, Mr John Ilott noted that the Australian and New Zealand College of Anaesthetists (ANZCA) has:

… strengthened the internal professional conduct framework. We have also established a centralised complaints-handling process, which is for complaints to the college. While our education program has not been as extensive as that of RACS, we acknowledge the generosity of RACS in providing much of the material that they developed at their own cost, which has been made available to other colleges.\textsuperscript{57}

3.78 Similarly, the Royal Australasian College of Physicians (RACP) set up working party in 2015 to 'further ensure our current systems, policies, procedures and practices were robust'.\textsuperscript{58} Mrs Linda Smith, Chief Executive Officer of RACP told the committee that some of the changes introduced as a result include:
• improved compulsory supervisor training workshops;
• education leadership and supervisor support that allows identification of inappropriate supervisor behaviour and a process of working with supervisors to change behaviour;

\textsuperscript{54} RACS provided the committee with a draft MOU as part of its submission. See: RACS, \textit{Submission 113, Attachment 1}.

\textsuperscript{55} Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, \textit{Committee Hansard}, 1 November 2016, p. 44.

\textsuperscript{56} Committee of Presidents of Medical Colleges, \textit{Submission 14}, p. 2.

\textsuperscript{57} Mr John Ilott, \textit{Committee Hansard}, 1 November 2016, p. 44.

\textsuperscript{58} Dr Catherine Yelland, \textit{Committee Hansard}, 1 November 2016, p. 42.
• producing 'Creating a safe culture', a new e-learning resource for fellows, plus online curated learning collections on bullying and harassment;

• extensive assessment of the resources provided by other colleges; and

• implemented a 24/7 confidential online support service for fellows and trainees that is not just limited to problems they may be having in the workplace.59

3.79 However, the committee also heard concerns about the efficacy of these measures by colleges, and whether they are in fact having any real impact on reducing bullying and harassment. For example, Miss Elise Buisson from AMSA told the committee:

I do think there has been significant change, but I do not think it has been all surgeons. And I think that change has been focused within the College of Surgeons because the other colleges have not had that same pressure applied to them. We have developed this kind of media idea that it is the surgeons who are particularly at fault, whereas I think there are quite a lot of poorly behaving doctors who are not surgeons who are getting away with it just fine. There absolutely are some surgeons who are still behaving badly, but I do think it is substantially less than it was a year-and-a-half ago. Whether that change will be sustained for another 18 months or the 18 months after that I am a little less certain of.60

3.80 Similarly, Dr Michael Mansfield, discussing the increase in bullying he has seen throughout his career, described the professional colleges as 'impotent, with respect to any meaningful action, despite the window-dressing'.61

Need for greater coordination

3.81 Evidence to the committee highlights the need for coordination across the medical sector to address bullying and harassment.62 Beyondblue submitted that:

Action on bullying and harassment is everyone's responsibility. Governments have a role through enacting legislation and funding relevant programs. Statutory authorities have a role in overseeing adherence to legislation through education, investigation of complaints, and the enforcement of laws and penalties. Employers are required by law to create an environment that protects the health and safety of their staff. Employees are obliged to follow the law and the lawful directions of their employers.63

3.82 Evidence from the speciality colleges highlights that addressing bullying and harassment requires cooperation with hospitals and employers. The Australasian College of Emergency Medicine (ACEM) argued that:

59 Mrs Linda Smith, Committee Hansard, 1 November 2016, pp 44–45.

60 Miss Elise Buisson, President, AMSA, Committee Hansard, 1 November 2016, pp 26–27.

61 Dr Michael Mansfield, Committee Hansard, 1 November 2016, p. 12.

62 Australian Dental Association, Submission 6, p. 2.

63 Beyondblue, Submission 11, p. 2.
In order to address the culture of bullying, ACEM considers that hospital management or executives, as well as hospital governing bodies, must be held accountable for the culture of the organisations that they lead. Through addressing bullying issues associated with those who are responsible for establishing the culture of a workplace, positive changes for those working at all levels within the hospital could be achieved.\textsuperscript{64}

3.83 Similarly, the CPMC submitted that 'while all Colleges are making a considerable effort to improve processes they cannot do it alone and there needs to be agreed principles between all parties'.\textsuperscript{65} Mr Biviano from RACS told the committee:

\ldots the responsibility to end a culture of bullying and harassment does not reside with any one individual or entity. Employers, hospitals, governments, health professionals, industrial associations, regulators and other partners in the health sector must all commit to sustained action. While each of these groups can and should develop individual solutions, at the core of the issue is the need for cooperation and collaboration across the health sector.\textsuperscript{66}

3.84 Mr John Ilott, CEO of ANZCA, told the committee that:

Lasting improvements can only be achieved with the cooperation of the health services in both private hospitals and public hospitals.\textsuperscript{67}

3.85 A number of submitters suggested that better sector-wide coordination is an important step to address the lack of clarity and trust in existing reporting mechanisms. The AMA submitted that:

Greater cooperation between employers and colleges with respect to the development and implementation of bullying and harassment policies and in relation to complaints handling would be beneficial to all parties involved. The current environment discourages effective compliance both with respect to the development of well understood and effective policies, as well as in relation to having accessible and trusted complaints mechanisms.\textsuperscript{68}

3.86 As part of this coordination, RANZCP suggests that:

\ldots there should be further practitioner education in regards to bullying and harassment as practitioners are often confused about what should be reported to AHPRA and what should be reported to their workplace.\textsuperscript{69}

\textsuperscript{64} Australasian College of Emergency Medicine, \textit{Submission 4}, p. 2.

\textsuperscript{65} Committee of Presidents of Medical Colleges, \textit{Submission 14}, p. 1.

\textsuperscript{66} Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, \textit{Committee Hansard}, 1 November 2016, p. 42.

\textsuperscript{67} Mr John Ilott, Chief Executive Officer, Australian and New Zealand College of Anaesthetists, \textit{Committee Hansard}, 1 November 2016, p. 43.

\textsuperscript{68} AMA, \textit{Submission 9}, p. 3.

\textsuperscript{69} RANZCP, \textit{Submission 19}, p. 2.
3.87 Similarly, the ANMF noted that its policy statement on bullying and harassment asserts that 'the first level for raising a bullying complaint is within the workplace'. When this fails, nurses and midwives are advised to report the bullying to a range of state and territory based authorities, such as Occupational Health and Safety Regulators. 70

3.88 In 2016, the Victorian Auditor-General conducted an audit of four public health services to assess their effectiveness in managing the risk of bullying and harassment in the workplace. The Auditor-General's report into Bullying and Harassment in the Health Sector found that the leadership of health sector agencies 'do not give sufficient priority and commitment to reducing bullying and harassment within their organisations' and that the health sector is 'unable to demonstrate that it has effective controls in place to prevent or reduce inappropriate behaviour, including bullying and harassment'.71

3.89 The Victorian Auditor-General made a number of recommendations for health sector agencies, WorkSafe, the Victorian Public Sector Commission and the Department of Health and Human Services to better address:

- early intervention mechanisms to address bullying and harassment;
- management of formal complaints; and
- collaboration between agencies that have a role in the safety culture of the health sector.72

Committee view

3.90 The committee acknowledges the work undertaken across the medical sector, particularly by colleges, to address bullying and harassment. The professional colleges are uniquely placed to respond to the medical profession's concerning record of tolerating or ignoring bullying and harassment.

3.91 However, the committee notes that while work is being done, a genuine change in the way the profession responds to incidents of bullying and harassment remains to be seen. Substantial and lasting change is the only metric on which such efforts will be assessed.

3.92 The committee is pleased to see increased recognition that supports further work to encourage cooperation and coordination across the sector to eliminate bullying and harassment and remove any barriers to making complaints.

70 ANMF, Submission 99, p. 3.
Chapter 4
Responses and recommendations

4.1 As this report highlights, the committee has received evidence of considerable concern about the way in which medical complaints in Australia are handled, including the use of notifications as a tool of bullying and harassment.

4.2 While the focus of the terms of reference for this inquiry was on the medical complaints process, the committee is concerned by evidence that clearly shows that bullying and harassment remain prevalent across the medical profession, affecting patients and their families, medical practitioners, students and trainees.

4.3 The committee notes that, in principle, the medical profession has a 'zero tolerance' approach to bullying and harassment. The committee is encouraged by evidence it received from parts of the medical profession, particularly some of the speciality colleges, outlining recent steps they have taken to better address these issues.

4.4 However, as discussed in chapter 3, evidence to this committee highlights that bullying and harassment is a widespread and significant problem. The committee is concerned that despite assurances from witnesses representing medical professionals, including speciality colleges, a sector-wide change to the way bullying and harassment is addressed and managed remains to be seen. The committee was particularly concerned by evidence suggesting that medical students and junior doctors continue to be among the most frequent subjects of bullying and harassment.

4.5 The committee recognises that addressing bullying and harassment can only be addressed with the cooperation of all sections of the medical profession, including Commonwealth, state and territory governments, hospitals, speciality colleges and universities. Without a coordinated, sector-wide response to preventing such behaviour, it will continue to put patient safety at risk, and see capable and dedicated people leave the sector, to the detriment of the Australian health system.

4.6 The committee is particularly concerned by the number of individual submissions it has received from medical practitioners, nurses and patients sharing their experience with the complaints process. The committee recognises the substantial impact that a notification investigation can have on both the notifier and subject of the complaint. As outlined in chapter 2, the committee has heard from multiple practitioners and members of the public about the consequences of lodging a notification. Individuals have written to the committee detailing the significant and ongoing effects they have suffered. The calls for a Royal Commission from some submitters are just one illustration of the level of community concern about the prevalence and impacts of bullying and harassment in Australia's medical profession.

4.7 The committee agrees that these cases demonstrate possible systemic problems with the medical complaints process that go beyond the scope of this inquiry related to both the administration of the process, and the regulatory framework that governs it.
4.8 The committee agrees that the evidence it has received to date highlights the need for a new line of inquiry, including:

- the relationships between and roles of the different bodies involved in the complaints process;
- the administration and implementation of the complaints process; and
- the adequacy of the regulatory framework for managing complaints under the National Law.

4.9 This chapter recommends that the committee initiate a new inquiry to investigate these matters.

**New areas for inquiry**

4.10 This inquiry focused on the intersection between bullying and harassment in the medical profession – a problem identified to be prevalent across the profession by a number of studies – and the medical complaints process in Australia. As such, its primary focus was on the ways in which the complaints process may be open to misuse as a tool of bullying and harassment within the profession. However, in the course of investigating this issue, the committee identified the following aspects of the medical complaints process that warrant further inquiry.

**Relationships between different bodies**

4.11 One point made by many of the submitters and witnesses to this inquiry was that there are unclear boundaries and responsibilities amongst the many bodies involved in the regulation and administration of the medical profession. As illustrated in chapters 2 and 3, responsibility for different aspects belongs to the Australian Health Practitioner Regulation Agency (AHPRA), the National Boards for each profession, the health complaints entities in each state and territory, professional colleges and individual workplaces.

4.12 The management of a notification lodged against an individual practitioner may involve most or all of those bodies. Evidence to the committee in this inquiry suggests that there is some confusion among patients and medical practitioners as to the specific roles of each of these bodies in resolving complaints.

4.13 The committee agrees that these relationships – and the different responsibilities held by each of these bodies – require further investigation to determine whether any improvements can be made to better assist all parties to the complaints process achieve a satisfactory outcome.

4.14 The committee is particularly interested in examining the roles of and relationships between AHPRA, the National Boards, the State and Territory Boards, panels established by National Boards and the health complaints entities in relation to the complaints-handling process.

**Administration and implementation of complaints process**

4.15 As discussed in chapter 2, one of the key concerns raised by many submitters was about the administration and implementation of the complaints process. Submitters identified a wide range of concerns, including:
• the timeliness of the process;
• the level and manner of communication from AHPRA;
• the adversarial nature of the process;
• perceived issues with conflict of interest;
• the qualifications of AHPRA investigators; and
• the failure to recognise that bullying and harassment within the medical profession is a patient safety issue.

4.16 Evidence received during this inquiry indicates that the process as it currently operates does not have the confidence of the entire medical profession. In particular, the process' vulnerability to misuse as a tool of bullying and harassment warrants further investigation.

4.17 In particular, the committee considers that the question of the effectiveness of the current notifications and investigation process merits further attention. AHPRA's legislated purpose is ensuring public safety, yet the concerns raised with the notifications process by submitters to this inquiry were focused, in the main, on the use of this process as a tool of bullying and harassment. The committee intends to investigate the process more broadly to gain an understanding of how well it is fulfilling its role in protecting public safety and responding to complaints from patients and others.

4.18 The committee notes that the administration of AHPRA has already been the subject of an inquiry by the Senate Finance and Public Administration References Committee in 2011. However, that inquiry focussed specifically on the AHPRA's role in health practitioner regulation following the introduction of the national scheme in 2010, and only addressed the complaints process as a related issue. The committee agrees with the conclusion of that inquiry that 'further development of the complaints process is urgently required'.

_Adequacy of regulatory framework_

4.19 Following on from the previous area of further inquiry, the committee considers that there is scope for a broader investigation of the framework underpinning medical regulation in Australia. The committee notes that the National Registration and Accreditation Scheme (NRAS) has been the subject of several reviews since its implementation in 2010, most notably the 2015 Independent Review

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for the Australian Health Ministers' Advisory Council.\footnote{See: COAG Health Council, \textit{Independent Review of the National Registration and Accreditation Scheme for health professionals}, 2015, \url{http://www.coaghealthcouncil.gov.au/Projects/Independent-Review-of-NRAS-finalised} (accessed 24 November 2016).} However, these reviews have not focussed specifically on the regulatory principles and practices of the complaints process, which the committee regards as warranting detailed examination.

4.20 On the basis of evidence received as part of this inquiry, the committee does not have sufficient information to judge whether the concerns discussed throughout this report are problems with the administration of the National Law, or whether the underlying regulatory framework is itself in need of review. The committee therefore considers this an important area for more focused investigation. 

**Conclusion and recommendations**

4.21 The committee thanks all those who assisted in this inquiry by making submissions or appearing at the public hearings. Through the large volume of submissions and correspondence received for this inquiry, the committee was able to gain an understanding of the concerns expressed by many submitters at the forms bullying and harassment in Australia's medical profession takes.

4.22 The committee has established that there are significant concerns about the way in which medical complaints in Australia are handled, particularly the use of notifications as a tool of bullying and harassment. The cases highlighted by submitters have demonstrated to the committee that there are broader issues with the administration and regulation of the current medical complaints process that warrant investigation.

4.23 In particular, the committee was concerned by the evidence suggesting that Australia's medical complaints process – a system designed to ensure public safety and optimal patient outcomes – has been misused by some for their own purposes. A world-class health system requires an open, transparent and rigorous process for patients and others to raise concerns with the healthcare they receive, and the undermining of this process for vexatious purposes is unacceptable.

4.24 The committee recognises that the NRAS, now just over six years old, faced some implementation problems, particularly with regard to the management of individual complaints. The committee notes that AHPRA, along with the MBA and NMBA, has worked to improve this process. However, it is clear from the evidence received for this inquiry that the process does not have the confidence of the entire medical profession. Just as a complaints process is a necessary component of a health system, practitioner confidence in the fairness and transparency of that system is necessary.
Recommendation 1

4.25 The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:

- acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike;
- recognise that working together and addressing these issues in a collaborative way is the only solution; and
- commit to ongoing and sustained action and resources to eliminate these behaviours.

4.26 The committee agrees that bullying and harassment should be addressed at the very first opportunity – at university. The committee considers that it is imperative that students are prepared at university to feel comfortable about making a bullying and harassment complaint, to know who has responsibility for them during placement and subsequent employment, and to know their options in making a complaint and any appeal processes that may be available to them.

Recommendation 2

4.27 The committee recommends that all universities adopt a curriculum that incorporates compulsory education on bullying and harassment.

4.28 The committee is particularly concerned by evidence that indicates a lack of clarity around reporting bullying and harassment for medical students while on placements in hospitals. The committee notes evidence from Ms Elise Buisson, President of the Australian Medical Students' Association, who told the committee:

In a hospital, if you are being taught by a doctor—which does not mean that they are employed at the university anyway, it just means that you are following them around for perhaps three months at a time—and you make a complaint against that doctor, that complaint needs to be made to the hospital ostensibly, but you are not covered by hospital policy. That generally covers employees and volunteers, and you are neither.3

4.29 The committee agrees that universities need to accept responsibility for students who are on placement in a hospital so these students do not fall through the cracks of the system.

Recommendation 3

4.30 The committee recommends that all universities accept responsibility for their students while they are on placement and further adopt a procedure for dealing with complaints of bullying and harassment made by their students while on placement. This procedure should be clearly defined and a written copy provided to students prior to their placement commencing.

3 Miss Elise Buisson, President, Australian Medical Students' Association, Committee Hansard, 1 November 2016, p. 27.
The committee considers that all hospitals should be required to have a provision in their code of conduct that specifically states that bullying and harassment in the workplace is not tolerated. The code of conduct should also state that this applies to students and volunteers.

**Recommendation 4**

4.32 The committee recommends that all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students and volunteers.

4.33 The committee is concerned that despite the apparent prevalence of bullying and harassment identified by the speciality medical colleges, few practitioners have been formally sanctioned. The committee notes evidence from Mr John Biviano, Director of Fellowship and Standards, Royal Australasian College of Surgeons (RACS), who told the committee that RACS had 7 000 members; however, to date, none had been sanctioned for bullying and harassment.4

4.34 The committee considers that there should be a requirement on all speciality colleges to report each year on how many complaints their members have been subject to and how many sanctions they have imposed.

**Recommendation 5**

4.35 The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.

4.36 While this inquiry's focus has been on bullying and harassment, it has also identified broader systemic issues with Australia's medical complaints process that go beyond the scope of this inquiry's terms of reference. For that reason, the committee intends to establish a new inquiry focused on the process itself, rather than this inquiry's examination of the ways in which the process can be used and misused.

**Recommendation 6**

4.37 The committee recommends that a new inquiry be established with terms of reference to address the following matters:

- the implementation of the current complaints system under the National Law, including role of AHPRA and the National Boards;
- whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;
- the roles of AHPRA, the National Boards and professional organisations – such as the various Colleges – in addressing concerns within the medical profession with the complaints process;

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4 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 45.
the adequacy of the relationships between those bodies responsible for handling complaints;

whether amendments to the National Law in relation to the complaints handling process are required; and

other improvements that could assist in a fairer, quicker and more effective medical complaints process.

Senator Rachel Siewert
Chair
APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1 Confidential
2 Professor Paddy Dewan (plus a supplementary submission)
3 Name Withheld
4 Australasian College of Emergency Medicine
5 Australian and New Zealand College of Anaesthetists
6 Australian Dental Association
7 Australian Doctors' Fund
8 Australian Indigenous Doctors' Association
9 Australian Medical Association
10 Australian Medical Students' Association
11 BeyondBlue
12 National Health Practitioner Ombudsman and Privacy Commissioner
13 Department of Health
14 Committee of Presidents of Medical Colleges
15 Cultural Inspirations
16 Health Care Consumers’ Association of the ACT
17 Multicultural Communities Council of NSW and Chinese Community Council of Australia
Royal Australasian College of Medical Administrators
Royal Australian and New Zealand College of Psychiatrists
The Royal Australian and New Zealand College of Radiologists
AHPRA, Medical Board of Australia and Nursing and Midwifery Board of Australia
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Mr Kevin Doyle
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Dr Leong Ng
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Australian Medical Council

Dr Peter Ashton
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Dr James Fratzia

Dr Kerry Breen (plus twelve attachments and a supplementary submission)

Dr Margaret Fitzpatrick (plus three attachments)
Confidential

Confidential

Confidential

Confidential

MIGA

Aboriginal Health Council of WA and the Health Consumers’ Council of WA

Australian Society of Anaesthetists

Confidential

Royal Australasian College of Surgeons (plus two attachments)

Health Professionals Australia Reform Association

Confidential

Confidential

Dr John Piesse

Confidential

Confidential

Confidential

Confidential

Confidential

Universities Australia

Confidential

Name Withheld
Answers to Questions on Notice

1. Answers to Questions taken on Notice during 1 November public hearing, received from Dr Gary Fettke, 6 November 2016
2. Answers to Questions taken on Notice during 1 November public hearing, received from Australian Medical Students’ Association, 8 November 2016
3. Answers to Questions taken on Notice during 1 November public hearing, received from Associate Professor John Stokes, 8 November 2016
4. Answers to Questions taken on Notice during 1 November public hearing, received from Health Professionals Australia Reform Association, 8 November 2016
5. Answers to Questions taken on Notice during 1 November public hearing, received from National Health Practitioner Ombudsman and Privacy Commissioner, 10 November 2016
6. Answers to Questions taken on Notice during 1 November public hearing, received from Dr James Fratzia, 10 November 2016
7. Answers to Questions taken on Notice during 1 November public hearing, received from Department of Health, 11 November 2016
8. Answers to Questions taken on Notice during 1 November public hearing, received from Royal Australasian College of Surgeons, 11 November 2016
9. Answers to Questions taken on Notice during 1 November public hearing, received from Royal Australasian College of Physicians, 11 November 2016
10. Answers to Questions taken on Notice during 1 November public hearing, received from Australian and New Zealand College of Anaesthetists, 11 November 2016
11. Answers to Questions taken on Notice during 1 November public hearing, received from Australian Indigenous Doctors’ Association, 16 November 2016
Answers to Questions taken on Notice during 1 November public hearing, received from Australian Health Practitioner Regulation Agency, Medical Board of Australia, and Tasmanian Board of the Medical Board of Australia, 16 November 2016

Answers to Questions taken on Notice during 22 November public hearing, received from Australian Health Practitioner Regulation Agency, 28 November 2016

Correspondence

1 Response from Dietitians Association of Australia to adverse comments made during the public hearing on 1 November 2016

Tabled Documents

1 Building Respect, Improving Patient Safety, RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, tabled by Royal Australasian College of Surgeons, at Sydney public hearing 1 November 2016

2 Let's Operate with Respect, campaign information, tabled by Royal Australasian College of Surgeons, at Sydney public hearing 1 November 2016
APPENDIX 2
Public hearings

Tuesday, 1 November 2016
Portside Centre, Sydney

Witnesses
National Health Practitioner Ombudsman and Privacy Commissioner
GAVEL, Ms Samantha, Ombudsman and Privacy Commissioner

STOKES, Prof. John, Private capacity

MANSFIELD, Dr Michael, Private capacity

FRATZIA, Dr James Demetrios, Private capacity

FETTKE, Dr Gary, Private capacity

Australian Medical Students' Association
BUISSON, Miss Elise, President

Australian Indigenous Doctors' Association
ARMSTRONG, Dr Benjamin, Board Director
TATIAN, Dr Artiene, Board Director
RALLAH-BAKER, Dr Kristopher, Board Director
DUKES, Mr Craig, Chief Executive Officer
DINKLER, Mr Ludger, Policy Officer

Health Professionals Australia Reform Association
KANE, Dr Donald William, Chairman

Royal Australasian College of Surgeons
BIVIANO, Mr John, Director, Fellowship and Standards

Royal Australasian College of Medical Administrators
FROST, Professor Gavin, Dean of Fellowship Education

Royal Australasian College of Physicians
YELLAND, Dr Catherine, President
SMITH, Mrs Linda, Chief Executive Officer
Australian and New Zealand College of Anaesthetists  
ILOTT, Mr John, Chief Executive Officer

Australian Health Practitioner Regulation Agency  
AYSCOUGH, Ms Kym, Acting Chief Executive Officer; Executive Director, Regulatory Operations

Medical Board of Australia  
FLYNN, Dr Joanna, Chair

Nursing and Midwifery Board of Australia  
CASEY, Ms Veronica, Board Member

Department of Health  
SOUTHERN, Dr Wendy, Deputy Secretary  
HALLINAN, Mr David, First Assistant Secretary

Tuesday, 22 November 2016

Parliament House, Canberra

Witnesses  
Australian Health Practitioner Regulation Agency  
FLETCHER, Mr Martin, Chief Executive Officer

Australian Nursing and Midwifery Federation  
THOMAS, Ms Lee, Federal Secretary
COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

5 STRATEGY

5.5 Independent Review into Accreditation Systems

Members were advised at the November 2016 meeting that following consideration of recommendations from the final report of the *Independent Review of the National Registration and Accreditation Scheme for health professionals* (NRAS Review), the Australian Health Workforce Ministerial Council (AHWMC) requested that the Australian Health Ministers’ Advisory Council (AHMAC) commission an independent review of accreditation systems.

AHMAC has appointed Professor Mike Woods, a health economist best known for his twenty reviews into various policy issues while at the Productivity Commission, but now with the University of Technology, Sydney. He will liaise with the NRAS Review Implementation Governance Group (the governance group established to oversight implementation of recommendations from the NRAS Review) throughout the project.

The purpose of the review is to seek more substantive reform of accreditation functions by examining the scope, governance, structure, cost and reporting arrangements to improve the efficiency, transparency and the cost-effectiveness of accreditation systems.

Professor Woods was invited to speak to Council members at this meeting and accepted but had to cancel due to international prior commitments. He indicated that a draft initial report would become available in March and he expected to consult widely on it. A timetable is below which indicates that a final report is expected to be delivered to AHMAC in September 2017.

Considering there is no interim draft report to be considered, it is recommended that Board simply note the process and progress to-date. Secretariat will lock Professor Woods into a special consultative meeting once the paper has been released. It will likely occur in Sydney.

**Recommendation:** note the process to-date
## Project Overview and Timeframes

<table>
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<tr>
<th>Key project stages</th>
<th>Timing</th>
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<tr>
<td>Preliminary research, environmental scan and international comparative analysis</td>
<td>Oct 2016 – Jan 2017</td>
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<tr>
<td>Literature review and analysis. Re-examination of the work of the NRAS Review and other relevant reviews; draw on further information and findings to compare Australian accreditation process with other accreditation systems and international schemes. Preliminary consultations.</td>
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<td>National consultation</td>
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<td>Public release and promotion of a consultation paper identifying current arrangements, issues and feasible options for reform. Submissions invited from all interested parties.</td>
<td>Feb – Mar 2017</td>
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<td>Consultation forums to be held in each state and territory inviting participation from a wide range of interested stakeholders across health and education sectors and consumers.</td>
<td>Mar – Apr 2017</td>
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<td>Preparation and delivery of the final report</td>
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<td>Analysis of data and information from submissions and national consultation forums. Further research conducted as required. Follow up consultation as required.</td>
<td>May – Aug 2017</td>
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<tr>
<td>Delivery of a final report to AHMAC and the COAG Health Council providing recommendations for reform.</td>
<td>Sept 2017</td>
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Accreditation Systems Review:
National Registration and Accreditation Scheme for health professions

Review Bulletin: No. 1
October 2016

Commencement of the Accreditation Systems Review

On 10 October 2016, AHMAC released a Communique which announced the appointment of Professor Michael Woods as Independent Reviewer for the Accreditation Systems Review.

Professor Woods is currently Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney. He has Visiting Scholar status at Australian National University. Professor Woods has extensive experience in economics, the public sector and health policy. He has previously been Commissioner, then Deputy Chair, of the Australian Productivity Commission during which time he presided on over 20 national policy inquiries and reviews. Professor Woods has also been Under Treasurer for the Australian Capital Territory.

Background to the Review

The National Registration and Accreditation Scheme (NRAS) for the health professions came into operation on 1 July 2010. The Scheme was implemented through enactment of the Health Practitioner Regulation National Law in each state and territory (the National Law). The objectives and guiding principles of NRAS are set out in section 3 of the National Law and include:

- to facilitate the provision of high quality education and training of health practitioners
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners
- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce
- to enable innovation in the education of, and service delivery by, health practitioners.

In 2014, the Australian Health Workforce Ministerial Council commissioned an independent review of NRAS which identified significant concerns with the high cost, lack of transparency, accountability, duplication and approach of the existing accreditation processes. The NRAS Review recommended a number of measures to address these issues, including further exploration of the United Kingdom approach to accreditation.

In August 2015, Health Ministers accepted in principle the NRAS Review recommendations related to ‘Accreditation Functions’ but requested a more comprehensive review of accreditation processes within the National Scheme to inform further consideration.

Scope of the Review

The Accreditation Systems Review’s Terms of Reference require that it consider the findings of the 2005 Productivity Commission Report Australia’s Health Workforce and the NRAS Review and that it undertake further analysis of the Australian, UK and other international accreditation systems.
In particular, the Review is to address:

- the cost effectiveness of the existing systems for the delivery of accreditation functions
- governance structures including reporting arrangements
- opportunities for the streamlining of accreditation including consideration of other educational accreditation processes
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning
- opportunities for increasing consistency and collaboration across professions.

Professor Woods’ Report will provide advice to the Australian Health Ministers Advisory Council and the Australian Health Workforce Ministerial Council on options for reform of the accreditation system and structures to support a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community.

The Report is scheduled to be completed by September 2017.

The full Terms of Reference are at Attachment 1.

Consultation

Feedback from stakeholders about their direct experience within NRAS will play a key part in informing the Accreditation Systems Review; particularly to identify:

- the strengths and limitations of existing procedures and governance arrangements and opportunities for improvement
- key issues and concerns about enabling the continuous development of a flexible, responsive and sustainable Australian health workforce
- priority areas and options for reform.

All stakeholders and interested parties will have the opportunity to contribute to the Review. This includes attending the National Consultations to be held in all jurisdictions in 2017 and providing a submission in response to the Review consultation paper.

It is also recognised that a wide range of stakeholders have already provided feedback on the existing accreditation systems within Australia by participating in the 2014 NRAS Review through consultation forums and/or submissions. Indeed, many of the stakeholders also made significant contributions to the earlier Productivity Commission Report. The current Review will consider, utilise and build on this expert body of knowledge to develop a consultation paper that provides a comprehensive review of accreditation systems and seeks to address the issues raised by Health Ministers.

Further information

Further information on the national consultations and submission process will be announced in later Bulletins and posted on the Review of Accreditation Systems Review website at www.coaghealthcouncil.gov.au/AccreditationSystemsReview

To register your interest in this Review and to receive future Bulletins, or to contact the Accreditation Systems Review team on any other matter, please email: admin@ASReview.org.au
ATTACHMENT 1

Accreditation Systems Review: Terms of Reference

The Review of Accreditation Systems will provide advice to AHMAC on the governance, structure, cost, and reporting arrangements to improve the efficiency, transparency and cost effectiveness of the health professions accreditation system, to support a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community.

The Review is to address:

- cost effectiveness of the regime for delivering the accreditation functions
- governance structures including reporting arrangements
- opportunities for the streamlining of accreditation including consideration of the other educational accreditation processes e.g. Tertiary Education Quality Standards Agency (TEQSA) and Australian Skills Quality Authority (ASQA)
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning
- opportunities for increasing consistency and collaboration across professions to facilitate integrated service delivery.

The Review will:

1. Map current arrangements through which health professions accreditation functions are delivered and the quality of health professions training is assured in Australia. This should include mapping of existing governance arrangements for health professions accreditation across education sectors in which the education providers operate (higher education, vocational education and training, and the specialist colleges system), and examination of the governance arrangements through which:
   - accreditation standards are established
   - qualifying programs of study are assessed
   - the equivalence of qualifications of overseas trained practitioners is determined
   - national examinations and other assessments are conducted, for the purposes of entry to practise in the Australian health professions
   - ‘competent authorities’ in other countries are recognised.

2. Undertake a comparative analysis of key features of the systems for delivery of health professions accreditation functions in selected international jurisdictions. This should include an analysis of the scope, governance, cost and performance of these systems compared with the Australian system.

3. Review the findings and recommendations of previous reports that have addressed governance of health professions program accreditation functions, and other relevant documents, including:
   - the Productivity Commission’s 2005 research report titled Australia’s Health Workforce
   - the NRAS Review Final Report of 2014
   - the Australian Higher Education Standards Framework (Threshold Standards) 2015.
4. Assess how well the accreditation functions are meeting the objectives and guiding principles of the National Law.

5. Identify and analyse a range of feasible options for reform of the governance of health professions accreditation functions in Australia, and undertake a national consultation on these options.

6. Undertake a cost-effectiveness analysis of feasible options for reform of health professions accreditation functions, compared with the status quo, and make recommendations for a preferred option or options.

The advice to AHMAC and Health Ministers will include a report outlining options for reform of accreditation systems and structures. The final report will also include advice on any necessary legislative changes, and policy or administrative actions required to give effect to the preferred option/s and recommendations.
5.6 Health Workforce

There are two sections to this paper, 5.6.1 the Ministerial review and 5.6.2 the strategic policy issues raised by RANZCOG College President which broadly fit into the CPMC Strategic Plan.

5.6.1 Ministerial Review of Medical Places

The Media Release by Assistant Health Minister The Hon. Dr David Gillespie, MP on 14 December 2016 with the theme of Tackling Australia’s New Health Workforce Challenge correctly identified the new challenge of geographical distribution of doctors across Australia along with a projected oversupply of 7,000 doctors by 2030. However there has been an oversupply of graduates for the past three years with the well-publicised graduation of two groups of medical graduates in the one year without sufficient internships available. Government has frequently cited the inherent complexities of managing health workforce and has been heavily reliant upon the alternative plan of utilising international medical graduates/specialist to fill any voids.

Government is also finalising the review of the Specialist Training Program and CPMC has previously called for three year agreements to enable greater certainty in planning. Government has indicated the value of the program for the broader education and training of specialists in the system, but that more could be done to train in outer metropolitan and rural/regional centres especially for psychiatry.

Previous policy statements made by directors in relation to health workforce include:

- Multiple players involved in workforce planning in disparate areas of the Department of Health. STP is only one piece of the overall plan;
- NMTAN offers helpful work but it occurs in apparent isolation of other aspects of planning;
- Individual College negotiations occur with the Australian Government to cater for differences in training capacity so that where a three year is probably useful for many, there will be capacity issues among individual disciplines;
- There are challenges in attracting and retaining trainees in rural and regional areas and the lead time required for proper training may give rise to five year plans;
- A disconnect between elements of the training pipeline and the STP is a factor in the continuum and therefore cannot be considered in isolation of the broader workforce policy;
- More attention must be paid to working with the Medical Deans and jurisdictions in terms of the number and distribution of places;
- Colleges have been central to the data modelling exercises and those with undersupply (psychiatry) or oversupply (ICU, ED), and accuracy has improved over past few years;
- Merit in the establishment of an overarching strategy to address this disconnect in the pipeline noting Secretary Bowles did commit to the development of a national strategic plan for health workforce at a special meeting held in 2015.

The review should be seen as a positive step towards addressing the current challenge, and linking the two agencies (Health with Education) is important because advice proceeds from Health through Education to Immigration on skilled occupations in demand (aka the SOL List).

Approximately thirty three medical specialties are still listed with several obviously in oversupply in Australia. The list can be seen at: https://www.border.gov.au/Trav/Work/Work/Skills-assessment-and-assessing-authorities/skilled-occupations-lists/SOL.
COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

CPMC has been critical of this disconnect between the Department’s ability to collect and report on data but then taking no action to implement policy levers to control elements of the training pipeline. This concern will remain until a national strategy is developed, or some policy levers are installed which receive agreement from stakeholders who can act without government intervention.

It is clear some sort of intervention is required as the market is simply not strong enough nor oriented to the uncertainty of health care to sufficiently control an important element of health workforce supply and to ensure the principles of Medicare are maintained. To this end, the focus on addressing geographic maldistribution is warranted. The Modified Monash Model which superseded the ASGC-RA has transitioned to the GP Incentive Program with a view to Government considering other workforce programs. CPMC should consider what sort of model, options and incentives might work for attracting and retaining specialists in these areas of shortage.

Some policy questions should be considered in reviewing the request for input from the Department.

1. What guarantees can the Government provide that it has both an understanding of the problem and the skill base to effect change considering their track record over the past two decades?
2. Should Government lower the cap on medical student intake for a period of five years?
3. Would the introduction of a moratorium on the establishment of new medical schools be acceptable?
4. What sort of incentives will be acceptable to the medical community to encourage better distribution of quality medical professionals into areas of geographic need? Is the Modified Monash Model appropriate as a start?
5. New medical graduates are acutely aware of the need to maintain ‘face time’ with the specialists as they progress through the training pipeline, and the influential ones are generally located in metropolitan hospitals so how will the suggestion by MDANZ to flip the current training model work in practice?
6. What sort of leader is actually required in managing the workforce policy challenges, given the Government’s history in monitoring the trends and then not acting upon any signs of a problem? What guarantees can the Government provide that it has both an understanding of the problem and the skill base to effect change? The aim should be to avoid a bulge occurring.

The correspondence and paper from the Department is attached where Mr Hallinan requests input by 17 February 2017, and in discussion with the Department CPMC has obtained a short extension of time to enable any feedback to be prepared from the meeting.

A draft submission is attached for the Board to discuss.

**Recommendation for 5.6.1:** Board note and discuss the request and CPMC submission on medical workforce.
5.6.2 Strategic Workforce Policy Issues

Professor Robson will introduce discussion in relation to the following three issues:

1. **Relationship between trainee numbers and ability to guarantee specialist procedural access**
   
   This item relates to the issue of difficulty in training procedural specialists where in certain jurisdictions the public hospital system does not provide enough major procedures to train specialists, yet if Colleges try to reduce numbers of specialty trainees this is perceived by the ACCC as 'anti-competitive.' (Question added to Ministerial section: Will the Health Department support Colleges in matching trainee numbers with procedure numbers, so that we don't have large numbers of trainees with insufficient skills and experience to perform procedures?)

2. **Incentives to encourage specialists to move to rural and provincial regions**
   
   This item relates to what planning has occurred to encourage newly-qualified specialists to leave major centres and move to smaller communities.

3. **The National Maternity Framework**
   
   The framework can be accessed at:
   
   
   
   The view from RANZCOG is that GPs, rural and remote doctors, anaesthetists, paediatricians, obstetricians, and many other medical providers - appear to have been omitted, yet obstetric disasters are among the most expensive and shocking adverse outcomes around. (In a question to the Minister: Will there be Commonwealth leadership to promote collaboration, rather than division?)

**Recommendation:** Board note the above issues for discussion and appropriate action as required.
Dear Mr Hallinan,

Re: Assessment of the number and distribution of medical school places and medical schools

The Council of Presidents of Medical Colleges (CPMC) welcomes the review and acknowledges the history where twenty years ago Australia faced a significant policy challenge in having a limited supply of doctors, which prompted the Australian Government to introduce a suite of policies to double medical graduates, and expand medical training places. The resultant overall growth in the medical workforce has been satisfactory. However, any policy lever which is aimed at increasing supply will eventually run the risk of oversupply and in 2012, when data modelling showed a projected oversupply of doctors there was limited strategic action to control for it. The other unintended consequence was a geographic maldistribution of doctors which is a separate workforce challenge but largely remedied through incentives. Since then a further five years of growth has occurred in the medical school intake, combined with the establishment of new medical schools. The resultant bulge in the training pipeline of graduates and post graduates in years two and beyond has started to impact upon specialist training with more applicants than can be accommodated.

The role of the Australian Government is in the development of national strategic policy and an assessment of the number and distribution of medical school places in Australia is timely. The summary of facts paper adequately outlines the challenges underpinning how to ensure a well distributed medical workforce. It is clear the current national workforce challenge facing medicine relates to oversupply and geographic maldistribution. An additional and hidden challenge is in creating adequately supervised clinical training places, a necessary component across all phases of training.

The National Medical Training Advisory Network (NMTAN) comprises organisations with the particular expertise in the prevocational space to consider the challenges of, and solutions to addressing data gaps. The role of NMTAN needs to be strengthened to more formally advise Government on community workforce needs, career planning information and related workforce policy measures. CPMC recommends NMTAN prioritise workforce modelling of all medical specialties in 2017-18 to inform the review and to provide ongoing advice.

Support from the Medical Deans of Australia and New Zealand for the review to prioritise addressing the maldistribution of medical professionals across regional and rural Australia is welcome, as is support in relation to the number and distribution of medical school places and medical schools in Australia.
The supply into the pipeline at the medical school level needs to be controlled as an urgent measure, if any meaningful assessment of future demand and distribution requirements is to occur through NMTAN. CPMC recommends the intake be fixed at the current level for a period of five years.

Consideration must also be given to changing the mix of medical school places to target regional, rural, and remote health care needs by providing more places in these areas, and ensuring incentives exist for suitably qualified and experienced doctors to supervise them.

The Postgraduate Medical Education Colleges are responsible for the allocation of medical graduates to accredited intern training positions and some also allocate to Post Graduate Year 2 training positions. There are too many doctors in post graduate years two to five, and there is variable quality in training where unfortunately, this group of doctors as the least understood demographic. Indeed the Summary of Facts paper stated on page 3 that the number of trainees in PGY3 + years is unknown.

It is clear the medical training space is congested with the number of trainees, schools and regulatory processes at both the national and local jurisdictions. Government intervention is required to restore the balance in Australia’s medical workforce rather than reliance upon the market to shape reform.

CPMC notes the focus by jurisdictions on ensuring sufficient intern places for domestic graduates has been worthwhile, however it is clear that attention must now turn to the supply into the pipeline in particular, PGY2 years and beyond. NMTAN is best placed to examine and provide the advice on the number of doctors required and the distribution across Australia. Currently as noted above, Australia has a projected oversupply of doctors by 2030. Taking action in 2017 which affects the supply of medical students will inevitably impact upon the pipeline given the training time into specialty (which is a minimum of fifteen years) while it may also positively impact on supply into the broader pipeline as well as diverting into areas of need.

Australia has geographic maldistribution of doctors and CPMC recommends strengthening the Integrated Rural Training Pipeline (IRTP) with regional training hubs which provide for full training opportunities for rural specialist medicine. Within this reform package CPMC recommends the establishment of more general practice and other specialist training opportunities including policy incentives to encourage specialists to travel to regional and remote areas. CPMC recommends greater investment in regional postgraduate training and strengthening of general practice rural incentives to allow for prevocational doctors greater lengths of time in rural and remote communities. There is evidence to show that doctors who train in regional areas, remain there, and hence are more likely to service rural and remote areas.

CPMC recommends notice be forwarded to the Department of Immigration and Border Protection to place a temporary hold on the inclusion of medical specialties on the Australian Government’s Skilled Occupations List with the exception of psychiatry.

SIGNED
13 January 2017

Laureate Professor Nicholas Talley
Chair
Council of Presidents of Medical Colleges
6/14 Napier Close
Deakin ACT 2600

Dear Laureate Professor Talley

Assessment of the distribution of medical school places in Australia

On 14 December 2016, the Assistant Minister for Rural Health, Dr David Gillespie MP, announced that an assessment of the number and distribution of medical school places and medical schools would be jointly undertaken by the Department of Education and Training and the Department of Health. I have attached the Media Release for your information.

I am writing to seek the views of CPMC on the distribution of medical school places and clinical training activity and the effectiveness of the current geographic distribution of places in helping meet health workforce needs, especially in supporting post-graduate training in rural and remote areas.

While workforce modelling does not support expansion of medical school places, the Government wants to ensure that the medical school places and clinical training in Australia supports provision of health care in regional, remote and very remote areas.

The lengthy training time across the stages of medical training means that if adjustments to the distribution of places were to be considered, there would be a range of implications.

Without pre-empting the outcome of the assessment process, the advice of CPMC on the issues that the government should consider if a redistribution of medical places were considered necessary in future would be appreciated.

I have attached the *Summary facts and discussion questions* paper that has been provided to key medical stakeholders and to assist Commonwealth departments to work together on the assessment. You are welcome to respond to some or all of the questions included in the paper. You may also choose to address the scope of the assessment task in another structure if that is more relevant to providing the views of Presidents of Medical Colleges.
We are interested in obtaining a full understanding of the current situation and evidence and there may be some areas where all Presidents of medical colleges do not agree. If an individual college has a dissenting view they are welcome to provide advice on why this is the case.

On 17 February 2017, the National Medical Training Advisory Network (NMTAN) will be working with the Department of Health on the assessment of the distribution of medical school places in Australia.

Your views are sought ahead of the NMTAN’s consideration of this matter.

I would welcome your response by 7 February 2017.

As the assessment is a joint review undertaken by both the Department of Education and Training and the Department of Health, it is likely that information you provide will be shared across portfolios. The Department may also want to share your responses, or a summary of them, with the NMTAN. If you, or your members, have any concerns with either of these approaches please advise the Department.

Please contact Ms Jennie Della, Director, Professional Entry and Rural Training Section (02 6289 9640) if you require any further information.

Yours sincerely

Dave Hallinan
First Assistant Secretary
Health Workforce Division

Cc Ms Angela Magarry
CEO, CPMC

Encl
Media release
Summary facts and discussion questions paper
Assessment of the distribution of medical places and training – Summary facts and discussion questions

The challenge – a well distributed medical workforce

Australians need a health workforce that is well distributed and has an appropriate mix of health professionals who can work in a range of service settings. This is essential for meeting the future health care needs of the population.

The most significant health workforce issue in Australia is no longer one of total supply, but of workforce distribution. Current modelling for the medical workforce is estimating a potential oversupply of medical practitioners of around 7,000 by 2030.

Australians living in rural and remote areas generally face greater health challenges than their metropolitan counterparts. People living in rural areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities. On average, people living in rural Australia do not always have the same opportunities for good health as those living in major cities.¹

Medical services in some rural and remote towns can be inadequate or sometimes non-existent, impacting most on populations of extreme disadvantage.

Access to services in rural and remote Australia is more difficult due to geographical spread, isolation and sparsely populated areas that are far removed from established services. In addition, a high proportion of the population in remote areas are Aboriginal and Torres Strait Islander people, with a greater need of both services and a workforce that is culturally competent.

Some communities continue to have difficulty in attracting and retaining GPs, and other health workers, due to factors such as financial viability of services, lack of access to professional and personal support, inadequate infrastructure, and lifestyle factors.

Medical graduates are a national supply, with domestic graduates able to work in any geographical location once provisional, general or specialist medical practitioner registration is achieved (subject to bonding or return of service requirements).

For most medical specialties it takes as many, or more, years working in a postgraduate training program, rather than an initial university degree, to achieve a postgraduate vocational qualification.

As a result, any consideration of changes to the numbers of medical places allocated by the Commonwealth has implications for state/territory governments, as well as higher education providers,

because of the interdependence and considerable time lag from commencing as a medical student to completion of vocational training. Changing allocations of CSPs will have resourcing implications for all jurisdictions. For example, state/territory health portfolios provide salaried internships and employment for other junior doctor, and specialist-in-training, positions.

After more than a decade of rapid expansion of medical graduates, it is timely to assess the number and distribution of medical places and schools in Australia.

The assessment is being completed within the context of workforce modelling, two decades of workforce distribution policies, the expansion of higher education places, and the Government’s priority to address maldistribution of medical professionals across regional, rural and remote Australia.

Scope of the assessment of medical places

The assessment will cover:

- Medical workforce need in regional, rural and remote Australia by assessing existing workforce distribution data in relation to the current number and the distribution of the Commonwealth supported medical places across existing medical schools.
- Distribution of existing medical schools, campuses and clinical training sites/activities.
- Current trends in medical education and training across the stages of medical training, and the current situation in light of increased medical student numbers over the last decade or more.
- Recommendations for arrangements to consider and assess future expansion, reduction or redistribution of medical places/schools.
- Recommendations and options to ensure that decisions on allocation of medical places consider: regional, rural and remote targeting and training, implications for clinical training including the ‘downstream’ implications for health services employing junior doctors after they graduate, workforce need and maldistribution, and the implications for existing programs.

Purpose of this discussion paper

The summary facts and discussion questions are provided to inform stakeholder comments.

Stakeholder feedback will assist the Department of Health and the Department of Education and Training to analyse existing data and evidence. It will also inform the National Medical Training Advisory Network which will work closely with the Department of Health through the assessment process.
Summary facts

**Medical training pipeline**

Once a person completes medical school, which includes clinical training, they still have years of intensive clinical training ahead of them to become fully qualified as an independent practising specialist medical practitioner (see Figures 1 and 2). This training is necessary to meet eligibility requirements for: medical registration; specialist qualifications/registration; and eligibility for a Medicare provider number.

In 2015 there were over 43,608 doctors across the various phases of training: 16,959 students, 3,305 interns (post graduate year 1) doctors, 3,275 postgraduate year 2 (PGY2) doctors, and 20,069 vocational/specialist trainees (registrars). The number of trainees in PGY3+ years is unknown.2

All jurisdictions are supporting medical education and training of the medical workforce through hospitals and other service settings, although arrangements may vary across jurisdictions.

**Figure 1: Medical Training Length of Time per Phase**

<table>
<thead>
<tr>
<th>Training phase</th>
<th>Length of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Student (Professional Entry Degree)</td>
<td>4-6 year medical programs*</td>
</tr>
<tr>
<td>Prevocational: Internship (Postgraduate Year 1, PGY1)</td>
<td>1 year</td>
</tr>
<tr>
<td>Prevocational: Junior Doctor (Postgraduate Year/s, PGY2 +)</td>
<td>No mandatory time. 1-3 years (or longer)**</td>
</tr>
<tr>
<td>Vocational: Specialist Trainee (Registrar)</td>
<td>3-7 years (actual time is typically longer) ***</td>
</tr>
</tbody>
</table>

Notes: Time periods based on lengths and entry requirements of universities and medical colleges, as published in the Medical Training Review Panel 19th report. Actual length of training time can vary. Entry into each phase of training is highly competitive and individual circumstances vary.
* Graduate entry or school leaver entry. Does not include the training time for pre-requisites for graduate entry programs (e.g. completion of a Bachelor of Biomedical Science or Bachelor of Science as a pre-requisite to a Doctor of Medicine program).
** Entry requirements to vocational training programs vary by Medical College, however, most require completion of PGY2 and PGY3 as a minimum. Length of prevocational training time can be longer, as entry into specialist training programs is highly competitive.
*** Lengths of time depend on specialist medical college training requirements which vary. While the minimum time length varies from 3-7 years, a more typical time frame is 4-9 years as programs are highly competitive and entry into each stage or year of training is not guaranteed.

**Figure 2: Clinical training occurs at all phases of training (end point ‘Fellow’ of a medical college)**

Rural training pipeline

For most trainees, the current system only provides episodic opportunities to live and work in regional, rural and remote communities. At key points in their training and development, the structure of the training system and a lack of advanced regional, rural and remote positions tend to force new doctors back to the cities, where they often settle.

2 Medical Training Review Panel 19th report

DOH ref: D16-1453273, version 13 January 2017 (Final)
The Commonwealth Department of Health’s Integrated Rural Training Pipeline (IRTP) for medicine is being implemented to help retain medical graduates in regional, rural and remote areas by better coordinating the different stages of medical training within regions and building additional regional, rural and remote training capacity.

**Controls on medical student numbers**

Medicine is the only exception to the demand driven system of higher education funding, with the allocation of medical Commonwealth supported places (CSPs) at universities controlled by the Minister for Education and Training.

In 2015, medical students in CSPs were 78.8% of all medical students. Another 5.6% were domestic full-fee paying medical students and 14.9% were international full-fee paying medical students.\(^3\)

The current allocation of medical CSPs by university (across all years of study) is at Attachment A. These places are allocated by the Government and specified in each university’s Commonwealth Grant Scheme (CGS) funding agreement.

Medical CSPs are capped because of the heavy ‘downstream’ training burden associated with medical graduates. Because of this, the Minister for Health is consulted about changes in the number of medical CSPs.

The *Higher Education Support Act 2003* (HESA) does not prohibit universities from offering domestic full-fee paying places in postgraduate courses. However, for universities with existing medical CSPs, their funding agreements include clauses that set limits on domestic full-fee paying intakes and domestic completions. Where a university has no existing medical CSPs and does not request any CSPs to be allocated to establish a postgraduate (above Bachelor level) full-fee paying medical course, the Government has limited leverage to influence the university’s decision.

The Government also has no control over a private university which does not receive funding for medical CSPs from establishing a medical program at either the undergraduate or postgraduate level. This is the case for Bond University which offers a medical program but does not receive funding for medical CSPs.

The Government does not control the supply of international full-fee paying medical students studying in Australia. In 2012, university medical schools, through the Medical Deans Australia and New Zealand (MDANZ), agreed to a soft cap on 2013 international medical enrolments to achieve 2012 graduating levels. This was done to align medical student training numbers with workforce need and in light of acknowledged pressures on the clinical training and internship system. Commencing international students are provided at Attachment B.

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\(^3\) MTRP 19\(^{th}\) report (refer Table 2.5)
**Medical student expansion and training**

Expansion of medical training (and the medical workforce) over the last two decades means the overall national supply of medical graduates is no longer the issue.

Australia has more than doubled its medical graduates in just over a decade. These increases will assist in meeting community needs for health services, but understandably are placing pressure on the system to support internships and specialist training places for new graduates. Table 2 in Attachment B describes medical student commencements, completions and projections over 2005 to 2019.

From 2000 to 2012, the number of medical schools across Australia increased from 10 to 18. Of these, 17 have allocations of CSPs. From 2017, Curtin University’s medical school will bring the total number of medical schools in Australia to 19.

Australian medical students are trained in a wide range of hospital, community and general practice settings, to ensure exposure to a variety of patients and medical conditions and service models.

To ensure high quality training, medical schools and their programs are accredited by the Australian Medical Council, prior to programs of study being approved by the Medical Board of Australia, and are subject to regular review.

**Clinical training of medical students**

In 2014, over 12.2 million hours of medical student clinical placement activity occurred in Australian service settings, 79% of this was in public hospitals. Over 9.9 million hours, or 77%, of this activity was undertaken in major cities. 4

Medical student clinical training activity standardised by population and presented by state/territory and remoteness is at Attachment D. 5

Medicine has the highest average clinical training placement hours required by higher education providers of any professional entry health profession (3,477 mean hours in 2014, with requirements varying from 2,222 to 4,520 hours).

While the accreditation standards do not specify minimum clinical placement hours for medicine, the former Health Workforce Australia’s work identified minimum efficient pathways for health professional entry programs, and for medicine this was identified as 2,200 hours.

**Rural training of medical students**

It is important to provide regional, rural and remote training opportunities at all stages of doctor training, especially for those most likely to practise rurally in the future.

Models for medical student rural training vary across universities,

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4 Clinical training survey data, Department Health 2015 (unpublished).
5 Clinical training survey data, Department Health 2015 (unpublished).
including the focus on training settings (hospital, primary care, hybrid models).

While there is evidence from the Commonwealth Department of Health’s Rural Health Multidisciplinary Training (RHMT) Program that students from a rural background, and those who complete long-term training placements in rural areas, are more likely to return to a rural area to practise, a key consideration for this paper is whether there is any further evidence available about what factors most strongly influence post-training choices.

In 2015, 28% of commencing medical students in universities participating in the RHMT Program were from a rural background, and nearly 900 of 2,710 graduating medical students completed a year-long placement in a rural area (almost 33%).

In 2014, 2,457 medical students completed a 4 week rural training placement.

In 2006, at a Council of Australian Governments’ (COAG) meeting, state and territory governments agreed to guarantee all Commonwealth supported medical graduates an internship.

General practice settings

Teaching of medical students in general practice is encouraged through the Commonwealth Department of Health’s Practice Incentive Program (PIP) Teaching Payment. Over the period 2000-01 to 2015-16 teaching sessions have increased from 38,039 to 223,894.

Internship guarantee for Commonwealth supported students

States and territories provide the bulk of clinical training to medical students and provide salaried internships and employment for other junior doctor and specialist-in-training years required to become a general practitioner or other medical specialist.

State and territory governments have advised that they have limited capacity in the public sector to increase clinical training activity for medical students and the required internship year following graduation.

The Commonwealth funds a small number of intern and junior doctor positions in rural and private settings.

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6 Department of Health, RHMT program administrative data (unpublished)
7 Department of Health, RHMT Training program administrative data (unpublished). Prior to 2016 participating medical schools were required to provide at least 4 weeks rural training for all medical students. Under the consolidated RHMT Program Framework 2016-18 this requirement has changed to ensure that all Commonwealth-supported medical students have an opportunity to undertake a structured rural placement (ASGS-RA 2-5), with at least 50% completing a rural training experience of at least 4 consecutive weeks during their degree course (includes one year long placements).
8 PIP teaching payment sessions are reported in the Department of Human Services annual reports. Note the PIP teaching payment incentive amounts (for each 3 hour teaching session) have changed over time. The incentive was doubled in 2004 (from $50 to $100 and doubled in 2015 from $100 to $200).
Prevocational trainee (junior doctor) expansion

Over the period 2011 to 2015, internship commencements have increased by 21.4%, from 2,723 to 3,305 postgraduate year one (PGY1), and PGY2 commencements have increased by 29.9%, from 2,521 in to 3,275.9

The provision and allocation of internship positions and junior doctor positions remains the primary responsibility of states and territories as they are the major employers of interns and junior doctors. Collectively, over the last decade, they have doubled the number of internships available each year.

The substantial increase in medical graduates and the pressure it has created on state and territory-run hospitals and clinical supervisors is documented in numerous reports and accounts of medical education and training stakeholders and experts.10

Hospitals in particular have had to adapt to more students and doctors-in-training in the workplace.

Rural intern positions

In 2015, there were 684 rural intern positions where PGY1 trainees could undertake the majority of their internship in a rural location.11

Distribution of intern training and ensuring opportunities for junior doctors to complete internships and other junior doctor training in regional and rural areas remains a challenge.

Vocational trainee expansion

Vocational trainees have more than doubled since 2000. In 2000, there were 6,613 vocational trainees, increasing to 20,069 in 2015.

Vocational training is highly competitive and while Figure 1 describes a range of 3-7 years, the actual time taken to achieve fellowship of a medical college could be considerably longer.

Specialist rural training

Statistics derived from the National Health Workforce Dataset (NHWDS)12 demonstrate that the level of non-GP specialist rural training is still quite low, with some 13% of all specialist trainees identifying as being based outside the major metropolitan areas in the 2015 workforce survey.

Given a regional and rural population share of approximately 33%, the data indicates that medical specialist training continues to be disproportionately located in major cities, even after accounting for

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9 MTRP 19th report. Note: PGY2 data is not readily comparable across states and territories and has limitations related to variations in available administrative data.
10 E.g. Medical Intern Training Review – Final Report, AMA position statement on “Support for non-vocational trainees prior to entering a vocational training program”, 2016.
11 MTRP 19th report (see Table 3.3a)
12 The data from the annual national registration process for 14 health professions, together with data from a workforce survey that is voluntarily completed at the time of registration, forms the NHWDS. Data in the NHWDS includes demographic and employment information for registered health professionals.
potential errors in the estimate\textsuperscript{13}.

Specialist training is particularly unlikely to occur in Remote and Very Remote (ASGC RA 4-5) areas, with only 75 trainees identified by the survey in 2015.

Of those specialist trainees identified through the NHWDS workforce survey, almost 1,600 are located in regional, rural and remote areas.

The Commonwealth Department of Health’s Specialist Training Program, while only providing approximately 5\% of all non-GP vocational training, has focussed on expanding the settings in which training occurs to include rural areas and private settings.

Doctors waiting for vocational training places “the bottleneck”

There is growing concern among medical education and training stakeholders about non-vocational trainees, especially those who have completed an internship but are yet to enrol in a vocational training program.\textsuperscript{14} These doctors are employed in salaried positions in hospitals and want to gain entry into a vocational training program.

Self-reported workforce survey data indicates that in 2014 there were 15,791 doctors intending to train in a specialist training program. In 2015 this figure was 16,411.\textsuperscript{15}

From 2005 to 2015, the number of hospital non-specialists working in a clinical role grew from 6,632 to 9,745. This represented an increase in the full-time equivalent rate from 38.6 hospital non-specialists per 100,000 population in 2005 to 48.8 in 2015.\textsuperscript{16} Non-vocational trainees waiting to enter a vocational training program are a part of this growing group of medical practitioners, as are those in junior doctor positions and those who choose to remain and work in hospitals as Career Medical Officers, Hospital Medical Officers or similar roles.

In 1996, the Australian Government introduced major changes to Medicare provider number access for new medical practitioners. Newly graduated doctors were required to obtain postgraduate qualifications before they could obtain Medicare access, unless they were enrolled in an approved training or workforce scheme. These changes had the effect of encouraging new doctors to work towards Fellowship of a recognised medical college and supported the establishment of general practice as a distinct discipline.

\textsuperscript{13} Comparisons between the ‘training’ classification data in the NHWDS and specialist college data on trainees show that the NHWDS consistently undercounts trainees by 10-30\%. Furthermore, as trainees tend to regularly rotate through training positions, their location according to the NHWDS data is more likely to be reflective of their residential address.

\textsuperscript{14} E.g. AMA position statement on “Support for non-vocational trainees prior to entering a vocational training program”, 2016.

\textsuperscript{15} National Health Workforce Dataset (NHWDS) – accessible at: www.health.gov.au

\textsuperscript{16} Australian Institute of Health and Welfare, Medical Practitioners 2015 (Figure 4)
In 2004-05 there were 2,940 non-vocationally registered (NVR) general practitioners providing Medicare rebateable services at the NVR lower schedule fee. In 2014-15, this number had risen to 4,786.  

**Recent workforce expansion**

Medical workforce in Australia has expanded rapidly in recent years even when population growth is taken into account.

The numbers of doctors per person has increased in all remoteness areas and across both general practice and other specialties.

Over 2000-2014, the number of new fellows entering medical specialities grew from 1,126 to 2,993 (165.8%). Within that, new GP fellows increased 251.5% over the same period.

The recently released AIHW report *Medical Practitioners 2015* indicates that the most significant health workforce issue in Australia is no longer one of total supply, but of distribution of medical specialists.

The number of medical practitioners registered with Australian Health Practitioners Regulation Agency in 2015 was 102,805. Of these registered medical practitioners, 88,040 (85.6%) were employed in the medical workforce, and 95.1% of all employed medical practitioners worked in a clinical role.

The number of registered medical practitioners has increased in the period 2012 to 2015 by 11,301 (11.0%), while the number of employed medical practitioners has increased by 8,387 (9.5%) over the same period.

In 2015, for every medical practitioner not renewing their registration there were 2.4 new registrations.

In 2004-05 there were 14,573 GPs (72.2 Full Service Equivalent GPs per 100,000 population), rising to 22,005 GPs (91.9 FSE GPs per 100,000 population) in 2014-15.

Summary statistics on the distribution of medical practitioners is in Tables 4, 5 and 6 at Attachment E.

**National medical workforce projections**

The Commonwealth Department of Health draws its views on medical workforce numbers from detailed modelling and projections undertaken for COAG Health Ministers.

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18 MTRP 19th report
19 NHWDS
20 NHWDS
21 Full service equivalent (FSE) is more meaningful than simple headcounts when monitoring the availability of medical practitioners, as not all practitioners work standard hours. One FSE is the statistical equivalent of a workload of 7.5 hours per day, five days per week.
The *Australia’s Future Health Workforce – Doctors* report (2014) provides projections to 2030 using registration and survey data.\(^2\)

The report favoured a ‘most likely’ scenario based on long range forecasts of growth in Gross Domestic Product (GDP), correlating the state of the economy to demand for medical services and therefore doctors, coupled with a modest two per cent productivity gain over the projection period.

Under this most likely scenario an oversupply of 7,052 doctors is projected by 2030.

The medical workforce modelling published in *Australia’s Future Health Workforce – Doctors* report also demonstrates an emerging mismatch between the number of trainees seeking a vocational training place and the availability of places based on community need.

This mismatch emerges from around 2017 and extends to approximately 1,000 places by 2030. It is likely that this mismatch between trainees seeking places and availability based on workforce need has become larger since this modelling was completed.

Whilst the report predicts a national oversupply of doctors, it also acknowledges that in rural and remote areas there are disparities in supply and that certain medical specialties are not in balance.

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Discussion Questions – Medical School Places and Distribution

The following are provided to promote consideration of the issues and seek advice on the distribution of medical schools, medical places and clinical training. They are not prescriptive.

<table>
<thead>
<tr>
<th>When responding:</th>
<th>When responding to the specific discussion questions below there are two particular filtering questions that you should consider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your response the same for each remoteness area?</td>
<td>To the extent possible, make distinctions between remoteness areas: inner regional; outer regional; remote; and very remote geographic areas; and/or specific locations/town sizes.</td>
</tr>
<tr>
<td>What is the available evidence that informs your views and/or recommendations?</td>
<td>To the extent it is available, reference evidence that supports your advice, especially where the information is not readily accessible in the public domain or through datasets the department can access (such as those drawn on in this paper). In particular, ensure you include reference to the strongest available evidence on how location of training (and/or rural background of students) relates to the location of eventual medical practice. Advice is also welcomed, where it is relevant, on identified gaps in evidence, or work underway to build the evidence which is not yet available to inform policy decisions.</td>
</tr>
</tbody>
</table>

Specific questions

When considering the following questions consider the above filtering questions.

Current trends

This question provides an opportunity to comment on current trends and what they mean for future medical education and training across all stages (student, intern/junior doctor, and registrar years).

1. What are the current trends in medical education and training, across all stages of medical training, and the implication of these trends for the training of doctors?

Commonwealth supported places (CSPs) and controls on medical places

The following questions are focussed on allocation of medical CSPs, and controls administered through the Commonwealth Education and Training portfolio.

2. How effectively does the current distribution of medical schools with CSPs address workforce need, particularly in regional, rural and remote areas?

3. How would expansion, reduction or redistribution of medical schools/medical places, to target regional/rural/remote health care needs, impact on the number of doctors practising in these locations?
Include advice on the implications of changing the distribution of existing medical places/schools for existing arrangements and the issues to be considered.

4. **What key factors should be considered to achieve a sustainable, well distributed medical workforce that provides access to quality medical services in all remoteness areas, and which factors are most relevant to future allocation of medical Commonwealth supported places/schools?**

5. **What role can/should full fee paying places (international and/or domestic) play in addressing medical workforce need?**

**Clinical training**

Include evidence of any gaps in clinical training locations and/or any existing clinical locations or settings that are underutilised or overburdened.

Include information on barriers or constraints and how these could be addressed.

The following questions are focussed on clinical training which occurs in a wide variety of geographic locations and services.

6. **Is clinical training for medical students geographically well distributed, or are changes needed?**

7. **What are the key factors to providing, and improving, high quality clinical training experiences, in particular in remote and very remote Australia?**

8. **What is the availability, including constraints, on clinical supervision, and/or pressures on clinical supervisors (across the stages of medical training, from medical school through to postgraduate training and/or across different remoteness areas)?**

**Rural training during medical school years**

Distinguish between different aspects of rural focus, selection of rural background students, location of campuses/clinical schools/rural health schools, provision of additional support for rural students, and/or depth/breadth of training opportunities provided, length of training at a specific location versus a variety of locations.

Comment on any evidence about whether particular models are more effective than others (such as: graduate entry vs school leaver entry courses; hospital-based vs primary care vs hybrid training models).

The following questions are focussed on rural training during the medical school years, and how selection of students with a rural background (and associated supports and programs), influence if students eventually practice in regional, rural and remote areas. Rural training is inclusive, but broader than, clinical training occurring in rural areas.

9. **What is the best available evidence on medical school programs, extent of their rural focus, and influence on doctors ultimately working in areas/locations of workforce need?**

10. **In some rural locations multiple universities are providing rural training for their medical students. Are these arrangements effective and/or how are universities working together (and with health services)?**

11. **What are your views on running a full medical program in one specific geographic location, compared with more dispersed models of delivery, for achieving a sustainable well distributed medical workforce across all remoteness areas?**
All stages of medical training and achieving a sustainable well distributed medical workforce

While the key focus of this assessment relates to medical places/schools, achieving a sustainable and well distributed medical workforce requires rural training and rural practise opportunities at all stages of medical education and training and other factors.

Provide any further advice you consider critical to understanding the relative importance of the different stages of medical education and training to achieving a sustainable well distributed medical workforce that can improve access to quality medical services across all remoteness areas.
### Allocation of Commonwealth supported places and controls on medical places – 2016

**Table 1: 2016 Allocation Medicine Commonwealth supported places (and other controls in Commonwealth Grant Scheme Funding Agreements 2014–2016)**

<table>
<thead>
<tr>
<th>Higher Education Provider</th>
<th>Total Medical EFTSL</th>
<th>Commencing domestic full-fee paying (DFFP) annual limit NO MORE THAN</th>
<th>Domestic annual completions (CSP and DFFP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New South Wales</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Australian National University</td>
<td>360</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>University of Newcastle (Joint Medical Program with University of New England).</td>
<td>536</td>
<td>0</td>
<td>108</td>
</tr>
<tr>
<td>University of New England (Joint Medical Program with University of Newcastle).</td>
<td>300</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>University of New South Wales</td>
<td>1,191</td>
<td>0</td>
<td>199</td>
</tr>
<tr>
<td>University of Sydney</td>
<td>907</td>
<td>0</td>
<td>227</td>
</tr>
<tr>
<td>University of Wollongong</td>
<td>288</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>Western Sydney University</td>
<td>505</td>
<td>0</td>
<td>101</td>
</tr>
<tr>
<td><strong>Victoria</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deakin University</td>
<td>520</td>
<td>0</td>
<td>130</td>
</tr>
<tr>
<td>Monash University</td>
<td>1,510</td>
<td>0</td>
<td>75 (4yr)</td>
</tr>
<tr>
<td>University of Melbourne</td>
<td>1,020</td>
<td>45</td>
<td>300</td>
</tr>
<tr>
<td><strong>Queensland</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Griffith University</td>
<td>600</td>
<td>0</td>
<td>150</td>
</tr>
<tr>
<td>James Cook University</td>
<td>922</td>
<td>0</td>
<td>154</td>
</tr>
<tr>
<td>University of Queensland</td>
<td>1,224</td>
<td>0</td>
<td>306</td>
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<tr>
<td><strong>South Australia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flinders University</td>
<td>444</td>
<td>24</td>
<td>135</td>
</tr>
<tr>
<td>University of Adelaide</td>
<td>804</td>
<td>0</td>
<td>134</td>
</tr>
<tr>
<td><strong>Western Australia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Western Australia</td>
<td>870</td>
<td>0</td>
<td>205</td>
</tr>
<tr>
<td>University of Notre Dame Australia (includes Freemantle and Sydney)*</td>
<td>640</td>
<td>Not specified in funding agreement</td>
<td>212</td>
</tr>
<tr>
<td><strong>Tasmania</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Tasmania</td>
<td>465</td>
<td>0</td>
<td>93</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>13,106</td>
<td>2,993</td>
<td></td>
</tr>
</tbody>
</table>


* UNDA is a 'Table B' higher education provider with campuses in both Fremantle and Sydney. It has a single CGS Funding Agreement covering both campuses. UNDA is permitted to enrol both CSP and domestic full-fee paying medical places. Of the 212 annual domestic medical completions, around 160 are CSPs and 52 are DFFPs.
# Medical Student/Graduate Growth

## Table 2: Medical Students: Domestic and International commencements and completions, 2005 to 2019

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical students who commenced courses leading to provisional registration</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic</td>
<td>1,871</td>
<td>2,071</td>
<td>2,560</td>
<td>2,934</td>
<td>2,955</td>
<td>2,939</td>
<td>3,241</td>
<td>3,035</td>
<td>3,032</td>
<td>3,185</td>
<td>3,210</td>
<td>3,215</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>International</td>
<td>460</td>
<td>426</td>
<td>436</td>
<td>499</td>
<td>487</td>
<td>529</td>
<td>529</td>
<td>651</td>
<td>636</td>
<td>552</td>
<td>567</td>
<td>613</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,331</td>
<td>2,497</td>
<td>2,996</td>
<td>3,433</td>
<td>3,442</td>
<td>3,468</td>
<td>3,770</td>
<td>3,686</td>
<td>3,668</td>
<td>3,737</td>
<td>3,777</td>
<td>3,828</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical students who completed courses leading to provisional registration</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic</td>
<td>1,320</td>
<td>1,335</td>
<td>1,544</td>
<td>1,738</td>
<td>1,915</td>
<td>2,259</td>
<td>2,507</td>
<td>2,777</td>
<td>2,944</td>
<td>2,968</td>
<td>3,128</td>
<td>3,162</td>
<td>3,180</td>
<td>3,241</td>
<td>n/a</td>
</tr>
<tr>
<td>International</td>
<td>267</td>
<td>298</td>
<td>316</td>
<td>401</td>
<td>465</td>
<td>474</td>
<td>457</td>
<td>504</td>
<td>497</td>
<td>469</td>
<td>521</td>
<td>553</td>
<td>518</td>
<td>533</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,587</td>
<td>1,633</td>
<td>1,860</td>
<td>2,139</td>
<td>2,380</td>
<td>2,733</td>
<td>2,964</td>
<td>3,281</td>
<td>3,441</td>
<td>3,437</td>
<td>3,649</td>
<td>3,715</td>
<td>3,698</td>
<td>3,774</td>
<td></td>
</tr>
</tbody>
</table>

Source: Medical Deans Australia and New Zealand. Shaded are projections.

Note: In future, medical student commencements and projected completions will need to take account of:
- Curtin University Medical School, which commences intake to their five year school leaver medical program in 2017, initially with 60 unfunded CSPs.
- Macquarie University’s planned medical program which is to be a full-fee paying course (no CSPs requested), subject to accreditation and establishment.
Main sites of medical rural training under the Rural Health Multidisciplinary Training (RHMT) Program

There are 18 rural clinical schools that support rural training and clinical placements for medical students. The sites listed below are the main sites from the RHMT funding agreements with the Commonwealth Department of Health.

Some, but not all university departments of rural health also provide placements for medical students. In some locations rural clinical schools and university departments of rural health are integrated.

Given this, the below is not an exhaustive list of existing and planned rural training locations that are supported by universities.

<table>
<thead>
<tr>
<th>State/Territory of University Places</th>
<th>Main sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Albury/Wodonga, Coffs Harbour, Wagga Wagga, Griffith, Port Macquarie, Tamworth, Taree, Armidale, Dubbo, Orange, Broken Hill, Lismore, Grafton, Murwillumbah, Bathurst, Nowra, Bowral, Forbes, Grafton, Milton, Ulladulla, Mudgee, Murrumbidgee, Lithgow</td>
</tr>
<tr>
<td>ACT</td>
<td>Bega, Cooma, Bateman’s Bay, Goulburn, Young</td>
</tr>
<tr>
<td>QLD</td>
<td>Mackay, Cairns, Mt Isa, Thursday Island, Atherton, Toowoomba, Bundaberg, Hervey Bay, Rockhampton, Kingaroy, Stanthorpe, Warwick</td>
</tr>
<tr>
<td>VIC</td>
<td>Warrnambool, Ballarat, Shepparton, Wangaratta, Benalla, Bendigo, Cobram, Corowa, Echuca, Mansfield, Nururmakah, Yarrawonga, Mildura, Traralgon, Bairnsdale</td>
</tr>
<tr>
<td>SA</td>
<td>Renmark, Mt Gambier, Nuriootpa, Victor Harbour, Murray Bridge, Hamilton, Whyalla, Port Lincoln, Ceduna, Roxby Downs, Port Augusta, Port Pirie, Kadina, Maitland, Mt Barker, Barossa Valley</td>
</tr>
<tr>
<td>WA</td>
<td>Kalgoorlie, Albany, Broome, Bunbury, Busselton, Carnarvon, Derby, Esperance, Geraldton, Karratha, Kununurra, Narrogin, Northam</td>
</tr>
<tr>
<td>TAS</td>
<td>Burnie, Latrobe</td>
</tr>
<tr>
<td>NT</td>
<td>Darwin, Nhulunbuy, Katherine, Alice Springs</td>
</tr>
</tbody>
</table>
Distribution of Medical Student Clinical Training Activity 2014

The unpublished data in Table 3 provides a broad overview of geographic distribution of medical student clinical training activity occurring in Australia based on the best available evidence.

Table 3 reports 2014 clinical placement activity of medical students (survey profession code P08, activity in hours) by jurisdiction and remoteness (ABS ASGS RA 2011) and standardised by population using the ABS Estimated Resident Population (ERP).

Clinical placement activity for students studying medicine in 2014 was part of the Department of Health’s survey of higher education providers conducted in 2015. Completion was a requirement under the 2015 Clinical Training Funding program that has since ceased. While higher education providers were invited to participate in the survey of 2015 clinical placement activity, the response rate was lower, and as a result survey data on 2014 activity has been used as it provides a more complete national picture.
<table>
<thead>
<tr>
<th>State/Territory</th>
<th>ABS ASGS RA 2011</th>
<th>Medical Clinical Placement Hours 2014</th>
<th>ABS Estimated Resident Population (ERP) 2014</th>
<th>Rate per 100 people (rounded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Major Cities of Australia</td>
<td>2,957,375</td>
<td>5,587,479</td>
<td>52.9</td>
</tr>
<tr>
<td></td>
<td>Inner Regional Australia</td>
<td>630,646</td>
<td>1,444,089</td>
<td>43.7</td>
</tr>
<tr>
<td></td>
<td>Outer Regional Australia</td>
<td>62,902</td>
<td>447,447</td>
<td>14.1</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>11,226</td>
<td>31,004</td>
<td>36.2</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>8,332</td>
<td>8,453</td>
<td>98.6</td>
</tr>
<tr>
<td>ACT</td>
<td>Major Cities of Australia</td>
<td>152,936</td>
<td>384,286</td>
<td>39.8</td>
</tr>
<tr>
<td></td>
<td>Inner Regional Australia</td>
<td>1,710</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>QLD</td>
<td>Major Cities of Australia</td>
<td>1,758,886</td>
<td>2,935,011</td>
<td>59.9</td>
</tr>
<tr>
<td></td>
<td>Inner Regional Australia</td>
<td>301,419</td>
<td>956,692</td>
<td>31.5</td>
</tr>
<tr>
<td></td>
<td>Outer Regional Australia</td>
<td>424,218</td>
<td>691,778</td>
<td>61.3</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>23,039</td>
<td>79,547</td>
<td>29.0</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>20,293</td>
<td>59,419</td>
<td>34.2</td>
</tr>
<tr>
<td>VIC</td>
<td>Major Cities of Australia</td>
<td>2,710,431</td>
<td>4,486,398</td>
<td>60.4</td>
</tr>
<tr>
<td></td>
<td>Inner Regional Australia</td>
<td>568,846</td>
<td>1,106,147</td>
<td>51.4</td>
</tr>
<tr>
<td></td>
<td>Outer Regional Australia</td>
<td>81,293</td>
<td>244,612</td>
<td>61.3</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>384</td>
<td>4,510</td>
<td>8.5</td>
</tr>
<tr>
<td>SA</td>
<td>Major Cities of Australia</td>
<td>998,519</td>
<td>1,238,937</td>
<td>80.6</td>
</tr>
<tr>
<td></td>
<td>Inner Regional Australia</td>
<td>24,496</td>
<td>183,326</td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td>Outer Regional Australia</td>
<td>73,347</td>
<td>202,671</td>
<td>36.2</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>14,857</td>
<td>45,848</td>
<td>32.4</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>4,576</td>
<td>14,932</td>
<td>30.6</td>
</tr>
<tr>
<td>WA</td>
<td>Major Cities of Australia</td>
<td>959,123</td>
<td>1,979,082</td>
<td>48.5</td>
</tr>
<tr>
<td></td>
<td>Inner Regional Australia</td>
<td>34,713</td>
<td>235,102</td>
<td>14.8</td>
</tr>
<tr>
<td></td>
<td>Outer Regional Australia</td>
<td>47,598</td>
<td>188,799</td>
<td>25.2</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>39,347</td>
<td>104,868</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>12,594</td>
<td>65,538</td>
<td>19.2</td>
</tr>
<tr>
<td>TAS</td>
<td>Inner Regional Australia</td>
<td>266,708</td>
<td>338,315</td>
<td>78.8</td>
</tr>
<tr>
<td></td>
<td>Outer Regional Australia</td>
<td>83,029</td>
<td>165,997</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>2,160</td>
<td>8,061</td>
<td>26.8</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>560</td>
<td>2,389</td>
<td>23.4</td>
</tr>
<tr>
<td>NT</td>
<td>Outer Regional Australia</td>
<td>75,947</td>
<td>140,386</td>
<td>54.1</td>
</tr>
<tr>
<td></td>
<td>Remote Australia</td>
<td>52,377</td>
<td>49,882</td>
<td>105.0</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>10,995</td>
<td>54,811</td>
<td>20.1</td>
</tr>
<tr>
<td>Other Territories</td>
<td>Inner Regional Australia</td>
<td>-</td>
<td>408</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Very Remote Australia</td>
<td>500</td>
<td>2,802</td>
<td>17.8</td>
</tr>
<tr>
<td>Major Cities of Australia Total</td>
<td>9,537,270</td>
<td>16,611,193</td>
<td>57.4</td>
<td></td>
</tr>
<tr>
<td>Inner Regional Australia Total</td>
<td>1,826,828</td>
<td>4,265,789</td>
<td>42.8</td>
<td></td>
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<tr>
<td>Outer Regional Australia Total</td>
<td>848,334</td>
<td>2,081,690</td>
<td>40.8</td>
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</tr>
<tr>
<td>Remote Australia Total</td>
<td>143,391</td>
<td>323,720</td>
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<tr>
<td>Very Remote Australia Total</td>
<td>57,850</td>
<td>208,344</td>
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<tr>
<td>National Total</td>
<td>12,413,673</td>
<td>23,490,736</td>
<td>52.8</td>
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</table>
## Workforce Distribution 2015

### Table 4: Distribution Employed Medical Practitioners, 2015, by State and Territory

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>TAS</th>
<th>ACT</th>
<th>NT</th>
<th>OT</th>
<th>NS</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Total</td>
<td>26,696</td>
<td>20,728</td>
<td>16,956</td>
<td>8,537</td>
<td>6,394</td>
<td>1,797</td>
<td>1,552</td>
<td>1,033</td>
<td>7</td>
<td>104</td>
<td>83,804</td>
</tr>
<tr>
<td>General practitioner (GP)</td>
<td>8,620</td>
<td>7,080</td>
<td>5,679</td>
<td>2,819</td>
<td>2,162</td>
<td>675</td>
<td>444</td>
<td>317</td>
<td>5</td>
<td>22</td>
<td>27,823</td>
</tr>
<tr>
<td>Hospital non-specialist</td>
<td>3,087</td>
<td>2,226</td>
<td>2,073</td>
<td>1,178</td>
<td>618</td>
<td>149</td>
<td>223</td>
<td>162</td>
<td>0</td>
<td>15</td>
<td>9,731</td>
</tr>
<tr>
<td>Specialist</td>
<td>9,489</td>
<td>7,571</td>
<td>5,695</td>
<td>2,889</td>
<td>2,304</td>
<td>626</td>
<td>558</td>
<td>253</td>
<td>0</td>
<td>51</td>
<td>29,436</td>
</tr>
<tr>
<td>Specialist-in-training</td>
<td>4,861</td>
<td>3,513</td>
<td>3,098</td>
<td>1,407</td>
<td>1,174</td>
<td>315</td>
<td>285</td>
<td>274</td>
<td>1</td>
<td>13</td>
<td>14,941</td>
</tr>
<tr>
<td>Other clinician</td>
<td>639</td>
<td>338</td>
<td>411</td>
<td>244</td>
<td>136</td>
<td>32</td>
<td>42</td>
<td>27</td>
<td>1</td>
<td>3</td>
<td>1,873</td>
</tr>
</tbody>
</table>

| Non-clinician Total | 1,580 | 1,272 | 705  | 458  | 359  | 112  | 72   | 72   | 1    | 66   | 4,795     |

| Total FTE per 100,000 | 28,276 | 22,000 | 17,661 | 8,995 | 6,753 | 1,909 | 1,722 | 1,105 | 8    | 170  | 88,599    |
| 395.6 | 387.8 | 394.1 | 364.0 | 414.7 | 383.1 | 484.1 | 498.6 | 264.8 | 372.6 |      |          |

*Source: NHWDS: medical practitioners 2015*

### Table 5: Distribution of Employed Medical Practitioners, 2015, by State and Territory and Remoteness Area

<table>
<thead>
<tr>
<th>Major Cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Not stated</th>
<th>Total</th>
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<td>624</td>
<td>35</td>
<td>13</td>
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<td>22,000</td>
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<td>145</td>
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<td>17,661</td>
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<td>66</td>
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<td>6,753</td>
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<td>101</td>
<td>8,995</td>
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<td>10</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>170</td>
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| Total         | 70,073        | 12,035        | 5,134  | 828         | 359        | 88,599|

*Source: NHWDS: medical practitioners 2015. Remoteness Area as per ABS ASGS RA2011

*Note: Gaps indicate that those Remoteness area classifications do not apply to those jurisdictions*

### Table 6: Distribution of Full Service Equivalent (FSE) GPs, 2014 – 2015, by State and Territory, and Remoteness Area

<table>
<thead>
<tr>
<th>State</th>
<th>Major Cities</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote</th>
<th>Very Remote</th>
<th>Total</th>
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<td>5,564</td>
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<td>647</td>
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<td>266</td>
<td></td>
<td></td>
<td></td>
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<td>266</td>
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</table>

| Total | 15,852       | 4,038          | 1,783          | 220    | 113         | 22,006|

*Source: Australian Government Department of Health: statistics based on Medicare data. Remoteness Area as per ABS ASGS RA2011*

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23 Full time Workload Equivalent (FWE) and Full time Equivalent (FTE) are no longer used and have been replaced by Full time service equivalent (FSE). FSE is more meaningful than simple headcounts when monitoring the availability of medical practitioners, as not all practitioners work standard hours. One FSE is the statistical equivalent of a workload of 7.5 hours per day, five days per week.
National Medical Training Advisory Network (NMTAN)

NMTAN membership:

Commonwealth Department of Health
Australian Indigenous Doctors' Association Limited
Australian Medical Association
The AMA Council of Doctors in Training
Australian Medical Council
Australian Medical Students Association
Australian Private Hospitals Association
Catholic Health Australia
Central Adelaide Local Health Network Incorporated
Committee of Presidents of Medical Colleges
Confederation of Postgraduate Medical Education Councils
WA Health
Department of Health Victoria
Medical Board of Australia
Medical Deans of Australia and New Zealand
National Rural Health Alliance
NSW Ministry of Health
Royal Australasian College of Medical Administrators
Rural Doctors Association of Australia
The Royal Australasian College of Physicians
The Royal Australian College of General Practitioners
MEDIA RELEASE

14 December 2016

Tackling Australia’s new health workforce challenge

- Assessment of distribution of medical school places
- Government priority to address shortages of doctors in regional, rural and remote areas
- Workforce data does not support establishment of new medical school places
- Government to consider ways in which workforce need in regional, rural and remote Australia can best be addressed

Twenty years ago, Australia faced one of its most significant health workforce challenges. With a limited supply of doctors at the time, the Howard Government implemented a successful suite of policies which has been supported by successive governments in addressing this challenge. This led to the doubling of medical graduates, the expansion of medical training places and medical workforce growth over the last two decades.

Overcoming this significant challenge has also presented a new challenge - the geographical distribution of doctors across Australia.

“Recent data released in Australia’s Future Health Workforce Report – Doctors suggests that the overall national supply is no longer the issue, rather an oversupply of doctors by as many as 7,000 is predicted by 2030,” said Dr Gillespie.

“The Coalition Government is committed to providing quality, affordable and sustainable health care to people living and working in rural, regional and remote Australia.

“Just as we assessed the way we addressed the overall doctor shortage in Australia 20 years ago and responded with policies to tackle the challenge at the time, we must now do the same to meet this different challenge.”

To begin tackling this issue, the Minister for Health, Minister for Education and Training, and Minister for Rural Health have asked their respective Departments of Health and Education and Training to jointly assess the number and distribution of medical school places and medical schools in Australia.

“This assessment, to be undertaken over the coming months, will be considered within the context of existing workforce modelling and data, two decades of workforce distribution policies, the expansion of higher education places and the Government’s priorities to address the maldistribution of medical professionals across regional, rural and remote Australia,” said Dr Gillespie.
The National Medical Training Advisory Network (NMTAN) will work closely with the Department of Health through the assessment process.

The Government will continue to work in partnership with medical associations, local communities and state and territory governments to deal with the distribution challenge and deliver health care to all Australian communities.

The Coalition Government wants Australians, no matter where they live, to have access to quality health services. The Government is investing record funding in health as part of its commitment to strengthen the regional, rural and remote health system so that Australians living in these areas have access to the best care available.

“At key points in their training and development, the structure of the training system and a lack of advanced regional, rural and remote positions tend to force new doctors back to the cities, where they often settle,” said Dr Gillespie.

“We must ensure access to high quality postgraduate training for the existing numbers of medical students and recent graduates in regional, rural and remote Australia.”

The Government has recently invested $94 million in the Integrated Rural Training Pipeline that will help retain medical graduates in regional, rural and remote areas by better coordinating the different stages of medical training within regions and build additional regional, rural and remote training capacity.

It is expected the assessment will be concluded by April next year.

For more information, contact the Minister's Office on (02) 6277 4960
5 STRATEGY

5.7 Healthier Medicare Government Policy

The Healthier Medicare initiative includes three priorities: the Medicare Benefits Schedule (MBS) Review Taskforce; the Primary Health Care Advisory Group (PHCAG) and a review of Medicare Compliance Rules. The purpose is to allow consumer access to government reform priorities.

MBS Review Update

CPMC is involved in the Medicare Benefits Schedule (MBS) Review Taskforce, which is led by Professor Bruce Robinson, and structured to consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients. CPMC has three representatives on the taskforce. The work has produced an Interim report which can be found at: http://www.health.gov.au/internet/main/publishing.nsf/content/mbsr-interim-report

In terms of feedback from consultations the report highlighted:

- Four types of issues associated with current MBS items: overuse of low-value services, underuse of high-value services, obsolescence, and misuse.
- Health professionals and consumers reported that current MBS rules can at times impede the delivery of patient care.
- Where the gatekeeping function of referrals was seen as unnecessary, or where systems for repeat referrals wasted time and resources.
- Limitations on the number of services, scope of practice and the focus on volume-based fee for service inherent in the schedule.

On the issue of fees and benefits the report highlighted that health professionals tended to be concerned about MBS fees relative to other services or providers, while consumers were concerned about financial pressure caused by high fees and gaps. The issue of affordability was commonly associated with specialist services however many consumers reported that the MBS adequately provided for everyday GP visits. Specialist care was considered unaffordable.

The next steps include the following initiatives recommended to the Health Minister:

- Greater transparency
- Health professional audit and feedback
- An emphasis on outcomes rather than activities
- Supporting multi-disciplinary care
- Interim MBS items
- Better compliance
- A cautious approach to the removal of MBS items
- Evaluating the effectiveness of the Review

The Taskforce has identified the Committees which will comprise the second tranche of Clinical Committees as follows:

- Pathology (including priority reviews of blood transfusion services, iron studies, coagulation studies)
- Oncology (includes medical oncology and radiation oncology)
- Dermatology, allergy and immunology
The report highlighted a significant challenge in gaining the resources required to undertake and support the various Review Committees and the Taskforce itself, considering it has in addition to the 12 current Committees the intention to set up over 20 more to cover the full range of MBS items. There will be a review into allied health from the perspective of what is currently funded for chronic disease management services.

Attached below is the expected timeline for the remaining phases of the Review.

Primary Health Care Advisory Group Update

CPMC is also involved in the reform of the Primary Health Care System which has had issues in relation to the plan to introduce a Health Care Home model to improve care for patients with chronic and complex conditions. CPMC is concerned that despite government assurances that the model will provide a practice will a ‘home base’ for the ongoing coordination, management and support of their conditions, the funding mechanism is so poorly structured that no improved health outcomes will be achieved. Initial discussions with the Federal Minister have focussed on the risk of adhering to the recommended model for the above reasons and this was received well.

Medicare Compliance Rules Update

The third tranche of the reform process is improving Medicare compliance rules and benchmarks. The government has committed resources to work with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks.
At the February 2016 meeting the Council was advised of the intention by government to use better techniques such as analytics and behavioural economics to provide both government and clinicians with more detailed information to better manage practice. The government also committed to providing more transparency around fees charged by health professionals. The current status of this reform program is a little unclear.

Modernising Health and Aged Care Payments Services Program

While completely separate to the Government Review program, the Government announced on 19 October 2016 that it would replace the ageing IT system it uses to deliver Medicare payments to Australians. The approach is a joint development program between the Departments of Health and Human Services led by the Digital Transformation Agency to create a new system to support the continued ownership and operation of its Medicare, PBS, aged care and related veterans entitlement payments into the future. The new IT system will be created from existing commercial technology with construct itself based on consultations with health and aged care providers, and sector stakeholders to inform the final design. The timeline is for that consultation to end in February with requests for information from industry to occur afterwards.

The Government’s Mid-Year Economic and Fiscal Outlook allocated $29.7M of the funding to Health, $1.7M to Human Services and $100K to Finance.

CPMC invited to attend an information session presented by the Digital Transformation Agency on the first phase of user research that has been conducted on the Program. Initial discussion with Assistant Secretary Kate McCauley Medicare and Aged Care Payments Division held on 31 January 2017 highlighted the practicality of extensive consultations and the development process has been swift because the Departments have been utilising the Agile Management approach to business. CEO CPMC will provide regular updates on the process as required.

**Recommendation:** Board notes the status of the Healthier Medicare Reform Program across its three elements and timelines.
5 STRATEGY

5.8 Private Health Insurance Review Update

Australia has a population of just over 26 million people and of that approximately 11 million have some sort of private health insurance cover. Over the past two decades successive governments have used various mechanisms to maintain access for people to private health insurance because it frees up public hospitals generally, and it also allows for choice. In recent years in common with the public health funding, private health insurance sustainability has been impacted by the rising cost of health care, ageing of the population, the growth in chronic disease and consumer ability to pay for cover.

A review of the value of private health insurance for consumers and its long term sustainability was announced on 28 October 2015. The government undertook consultations to identify how private health insurance may be improved to deliver better value for money for consumers. The review coincided with a number of other changes under consideration by government including the White Paper on the Reform of the Federation, the reviews of primary health care and the Medicare benefits Schedule. The consultations have concluded.

The Australian Medical Association released its Private health Insurance report Card 2016 which was an attempt to clarify what PHI is, what cover means, why there are differences and then list all the funds available. The card can be found at https://ama.com.au/ama-private-health-insurance-report-card-2016

On 8 September 2016 the former Minister for Health announced the establishment of a Private Health Ministerial Advisory Committee to examine all aspects of private health insurance and to provide advice on reforms. The Minister wanted to have developed an easy-to-understand range of categories of health insurance with standard definitions for medical procedures across all insurers to provide greater transparency and simplify billing. In addition the advice needed to cover what people living in rural and remote Australia want and need.

The Committee membership comprises Dr Jeffrey Harmer, AO as Chair with a range of representatives from industry including consumers, public, private and not-for-profit sector providers and the Private Health Care Australia. A copy of the latest meeting minutes from December 2016 is attached as is the Committee workplan for the information of CPMC Board.

Professor Truskett is represented on the Committee and may wish to add further information to the above, and lead discussion accordingly.

**Recommendation:** Board notes the progress on the PHI review, for discussion.

Attach: Committee Membership and Workplan
1. Welcome, apologies and introductions

The Chair noted apologies for this meeting.

2. Product design

- The Committee continued discussions of the possible operational arrangements of a product design approach that categorises hospital products into Gold/Silver/Bronze tiers according to exclusions and excesses. The Committee considered the minimum product standards and excess levels that could apply under such a scheme, whether insurers should be permitted to apply restrictions and co-payments and the impacts such changes would have on premiums.
- The Committee noted that the Department will shortly engage actuarial support to undertake modelling and analysis of product design approaches being considered by the Committee.
- The Committee discussed the issue of policy restrictions; including ‘public hospital only’ products and the perceived value of these products for some consumers (for example people living in rural areas without ready access to private hospitals).
- The Committee considered data on the provision of mental health services funded by private health insurance and discussed the levels of mental health coverage that could be included within different tiers of hospital insurance.
The Committee noted that the Secretariat will prepare a paper for the next meeting outlining possible approaches for applying new classification arrangements to general treatment products.

3. **Private Health Insurance Premium Setting**
   - The Committee considered a private health insurance premium setting paper prepared by the Secretariat. The paper provided background on current private health insurance premium setting arrangements, stakeholder views and potential options for reform including increased regulation, modified regulation, price monitoring and deregulation.
   - Committee members discussed the merits of reform options and agreed that the Secretariat would further develop options for the Committee to consider at its next meeting.

4. **Information provision for consumers**
   - The Committee agreed the importance of ensuring that consumers have access to the right information to assist them to make informed decisions regarding private health insurance.
   - The Committee discussed current information provision requirements and opportunities for reform. The Committee noted that developments in information technology provide opportunities for better information provision.
   - The Committee noted the links between information provision, product design and standard clinical definitions, which will also be considered in early 2017.

5. **Out-of-pocket costs**
   - The Committee considered an out-of-pocket costs issues paper prepared by the Secretariat. The paper provided background information and data on hospital, medical and general treatment out-of-pocket costs. The Committee noted that the largest out-of-pocket costs occur in medical services.
   - The Committee discussed possible options to reduce out-of-pocket costs, noting the legal and political difficulties of regulating in this area. The Committee agreed to further develop options in relation to the provision of information to consumers and GPs.

6. **Contracting and Default Benefits Working Group**
   - The Committee agreed the Terms of Reference for the Contracting and Defaults Benefits Working Group.
   - The Committee noted the member nominations received for the working group and that a Chair has also been identified. The first meeting of the working group is scheduled for 2 February 2017.

7. **Improved value for rural consumers – update**
   - The Committee noted that the Improving the Value of Private Health for Rural and Remote Consumers workshop is being held on 12 December 2016. The Committee also noted an information paper that had been sent to workshop participants.
   - The Committee will receive feedback from the workshop at its next meeting.

8. **Other business**
   - The Committee noted that its next meeting is scheduled for Wednesday 1 February 2017.
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<th>Item no.</th>
<th>Issues for consideration</th>
<th>Proposed start</th>
<th>Proposed finish</th>
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<td>Contracting, minimum default benefits and second tier default benefits</td>
<td>November 2016</td>
<td>February 2017</td>
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<td>Private patients in public hospitals</td>
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<td>February 2017</td>
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<td>Risk equalisation</td>
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<td>end 2017</td>
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<td>Other regulatory issues, including Lifetime Health Cover and Medicare Levy Surcharge</td>
<td>mid 2017</td>
<td>end 2017</td>
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<td>12.</td>
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<td>end 2017</td>
<td>Yes</td>
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6.1 Trainee Wellbeing

This item is in relation to trainee wellbeing and recent trainee suicides and is to be introduced by the President of RANZCP Professor Malcolm Hopwood in conjunction with the RACP President Dr Catherine Yelland.

The background to the matter relates to recent discussions between Doctors Health and Beyond Blue concerning the issue of doctor suicide particularly whether it can be prevented and whether the suicide of doctors is the same as other community members or, whether there are particular features of this cohort which need to be addressed. The Doctors Health Board has been exploring whether research is required in this area and then how such research might be undertaken and funded.

Dr Jennifer Alexander provided CPMC with reference to the MJA article (19 September 2016 Vol 205 No 6 page 260 - 265 ) “Suicide by health professionals: a retrospective mortality study in Australia 2001-2012” by Allison Milner et al. The article summarises that "the rate of suicide for health professionals with access to prescription medicines was higher than for health professionals without ready access to these means”. Further, "suicide prevention initiatives should focus on workplace factors and differential risks for men and women employed as health professionals."

At the recent meeting of the Doctors Health Board, it resolved to explore

- How the Australian medical profession, as a whole, could be brought together to address doctor suicide and, in particular, the development of initiatives targeted to reduce doctor suicide.
- What further research might assist with the development of suicide prevention strategies and how this might be developed and financed.

To this end the DrHS will explore the feasibility of bringing key stakeholder groups together, such as the colleges, the AMA, Beyond Blue, health departments, MBA, medical defence/insurer organisations and researchers in the area of suicide prevention, for a one day seminar/Workshop on this topic to develop an action plan for the prevention of doctor suicide. DrHS has recently been given a small grant of $17,000 from the AMA, which closed some longstanding trust funds, some of which were established just after WW1. DrHS will put this money towards the seminar planning. It is hoped that the seminar might be able to be held by late Q2 or in Q3 this year.

College Presidents may wish to consider the issue in the context of how different Colleges are dealing with the issue, and the resources currently available to assist trainees in difficulty. One step would be for CPMC to send a note to Doctors Health to encourage them to develop a research study which has representation from Specialist Medical Colleges.

**Recommendation:** Board notes the issue of trainee wellbeing and discusses appropriate approach.
20 December 2016

Ms Angela Magarry  
CEO  
Council of Presidents of Medical Colleges  
Email: CEO@cpmc.edu.au

Dear Ms Magarry

Re: Inaugural Choosing Wisely in Australia 2016 Report

I am very pleased to present you with a report on Choosing Wisely Australia detailing the progress of the initiative since its launch in April 2015.

You may be aware Choosing Wisely Australia is part of a clinician-led global social movement that aims to promote better conversations between healthcare professionals and consumers around appropriate care options to improve the quality, safety and sustainability of our healthcare system.

NPS MedicineWise is an independent, not-for-profit and evidence-based organisation promoting quality use of medicines. We work nationally to improve the way medicines and medical tests are used in practice, and to enable better decision making by clinicians and consumers. As the facilitator of Choosing Wisely Australia, we support Australia’s medical profession to shine a light on unnecessary tests, treatments and procedures that may be ineffective, wasteful, and in some cases, potentially harmful.

To date 28 of Australia’s medical colleges, societies and associations have opted to become involved in Choosing Wisely Australia which is a phenomenal response. These organisations have released 123 recommendations on medical tests, treatments and procedures clinicians and health professionals believe should be questioned based on best practice and evidence.

The Choosing Wisely in Australia 2016 Report highlights progress nationally as we work towards changing clinician and patient attitudes and behaviours around inappropriate healthcare.

There is also strong momentum among Australia’s health services to implement the initiative in our hospitals, with seven currently on board and more who have expressed their interest in joining.

Strong enthusiasm and genuine engagement in Choosing Wisely Australia reflects the appetite across our health sector and community for better, more informed conservations around appropriateness of care choices.

If you have any questions on the report, or would like further information about Choosing Wisely Australia, I invite you to please contact Dr Robyn Lindner, Client Relations Manager (02) 8217 8771 or email rlindner@nps.org.au.

Yours sincerely

Dr Lynn Weekes AM  
Chief Executive Officer
Choosing Wisely in Australia

2016 Report

Promoting better conversations about the appropriate use of medical tests, treatments and procedures
Choosing Wisely Australia Report 2016
An initiative of NPS MedicineWise

Contents

2 Introduction
4 Key achievements
6 A global movement
7 How Choosing Wisely works
9 A clinician-led approach
12 A community conversation
15 Alignment of clinical and healthcare systems
18 Learnings and challenges
21 Appendix 1
   Attitudes and awareness of Choosing Wisely and unnecessary care
26 Appendix 2
   Choosing Wisely Australia Advisory Group
27 Appendix 3
   Choosing Wisely Australia members and supporters (April 2015 – November 2016)

We achieved so much together in our first year. Let’s continue the conversation...
Introduction

Dr Lynn Weekes AM, Chief Executive, NPS MedicineWise

I am pleased to present our first Choosing Wisely Australia report, which details our achievements since launching last year. It is evident from our work there is a strong appetite in the community for better conversations about the appropriate use of tests, treatments and procedures. More and more people are engaging in the concept of ‘more is not always better’ when it comes to healthcare.

Choosing Wisely is a global social movement aimed at supporting conversations between health professionals and consumers about the appropriate use of healthcare tests, treatments and procedures. Employing a ground-up approach driven by Australia’s health professionals and their specialist colleges, societies and associations, Choosing Wisely puts consumers firmly at the centre by identifying and reducing practices that are not evidence-based and potentially could cause them harm.

Key activities and outcomes achieved by Choosing Wisely Australia include:

- strong engagement by health professionals with 28 colleges, societies and associations becoming members
- broad health professional representation including GPs, specialists, nurses, surgeons, hospital pharmacists, physiotherapists, radiologists and pathologists
- strong interest from consumer advocacy groups and support from the Consumers Health Forum of Australia
- 123 recommendations highlighting healthcare approaches that should be questioned
- multidisciplinary agreement on need to improve management of end-of-life care, appropriate use of antibiotics and imaging cross-disciplinary conversations and collaboration on recommendations development and promotion of resources to support communication key ‘5 Questions’ consumer resource translated into 10 languages strong media coverage across all major media channels - TV, radio, press and online - reaching an audience of more than 18 million Australians recommendations incorporated into guidelines, education modules and hospital quality and safety improvement systems locally led implementation through professional and community partnerships.

Our surveys with health professionals and consumers identify some of the drivers contributing to unnecessary care. The results highlight a potential gap between the aspirations and actual behaviours of both consumers and health professionals regarding appropriate healthcare.

There are also contrasting opinions between health professionals and patients as to why unnecessary care happens, highlighting the need for better understanding through improved communication.

Promisingly, consumers who reported knowing about Choosing Wisely were more aware of the risks and harms associated with unnecessary care. Also, as a result of participating in Choosing Wisely Australia, 73% of participating medical colleges and societies have indicated they will consider how they can work with consumers to reduce unnecessary care.

Thank you to the Choosing Wisely Australia Advisory Group for your support and commitment to successfully delivering the initiative. Thank you also to all the Choosing Wisely Australia colleges, societies, associations, chapters, hospitals, practices, local health districts, consumer organisations and consumers who have shown such enthusiasm in leading the effort.

The initiative has come a long way but there is plenty of work ahead. If you haven’t already, we invite you to join the Choosing Wisely Australia conversation.

Dr Lynn Weekes AM
Chief Executive Officer
NPS MedicineWise

About NPS MedicineWise
NPS MedicineWise, an independent, not-for-profit and evidence-based organisation for quality use of medicines and medical tests, facilitates Choosing Wisely Australia. We identify and resolve challenges around the way medicines, medical tests and health technologies are prescribed and used. Our aim is to enable people to make the best decisions about medicines and related technologies. We receive funding from the Australian Government Department of Health.
Since it began in April 2015, interest and participation in Choosing Wisely Australia has reinforced the urgent need for a national conversation on the appropriate, safe and effective use of the country’s health resources.

The initiative is exerting influence on health decision making in different settings by:

- helping promote further discussions about unnecessary and low-value treatments and tests among health professionals and consumers
- informing tangible healthcare policy changes, structures and recommendations.

Key achievements

Since it began in April 2015, interest and participation in Choosing Wisely Australia has reinforced the urgent need for a national conversation on the appropriate, safe and effective use of the country’s health resources.

The initiative is exerting influence on health decision making in different settings by:

- helping promote further discussions about unnecessary and low-value treatments and tests among health professionals and consumers
- informing tangible healthcare policy changes, structures and recommendations.
How Choosing Wisely works

Choosing Wisely is governed by the following principles:

- Health profession-led to build and sustain the trust of both clinicians and patients
- Clear emphasis on improving quality of care and on harm prevention
- Patient-focused communication between clinicians and patients is a central tenet
- Evidence-based and reviewed on an ongoing basis
- Multidisciplinary – encouraging physicians, nurses, pharmacists and other healthcare professionals to participate
- Transparency – processes used to create the recommendations, as well as supporting evidence, are published.

The development of lists of recommendations by health professional organisations plays a critical role in starting important conversations about the problem of unnecessary care. The lists create a platform for change.

All the recommendations are available at www.choosingwisely.org.au/recommendations.

A global movement

Choosing Wisely is gaining traction across the world and is playing an important role in empowering health professionals and consumers to take an active role in reducing unnecessary healthcare.

Underpinning Choosing Wisely, and integral to its success worldwide, are two key guiding principles:

1. Health professionals lead the initiative, independently of government and/or payers
2. To improve the quality of healthcare for consumers by reducing unnecessary tests and treatments.

Choosing Wisely was launched in the United States in 2012 by the American Board of Internal Medicine Foundation, Consumer Reports and nine specialty medical societies. The initiative was developed in direct response to the lack of attention given to the overuse of tests, treatments and procedures and potential negative impacts for consumers. It has been estimated that 30% of all medical spending in the US is unnecessary and does not add value in care.

Each specialty society published lists of five recommendations for its specific discipline where there was strong scientific evidence of overuse and significant potential harm or waste. In publishing these lists, Choosing Wisely sought to encourage physicians and patients to have conversations about what care is truly needed, and debunk the notion that more is better.

In the US more than 70 specialty societies have collectively published more than 450 Choosing Wisely recommendations. The initiative has been the focus of more than 400 journal articles, and has well and truly entered mainstream conversation.

Canada launched Choosing Wisely in 2014 and similar initiatives now exist, or are being developed, in over 15 countries. Choosing Wisely Australia launched in April 2015.

‘The aim of the initiative is to both help identify and reduce investigations and treatments that are of proven low value, with the outcome of improving healthcare provided to Australians.’

Associate Professor Richard King AM, Chair, Choosing Wisely Australia Advisory Group

Our roadmap for implementation

It is widely acknowledged that lasting behaviour change requires multifaceted implementation strategies and in Australia implementation is being informed by the Choosing Wisely International Working Group framework.

Key elements of Choosing Wisely Australia (adapted from Levinson et al!)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities/outputs</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change clinician attitudes to practice</td>
<td>Engaging healthcare providers in list development and implementation</td>
<td>Multifaceted approaches including: process indicators, short- and intermediate-term impacts and longer-term outcomes</td>
</tr>
<tr>
<td></td>
<td>Incorporation into continuing professional development, curriculum and education</td>
<td>Short-term measures: Participation</td>
</tr>
<tr>
<td></td>
<td>Integration into existing programs</td>
<td>Reach</td>
</tr>
<tr>
<td></td>
<td>Medical and mainstream media campaigns, journal articles, conferences, partner newsletters</td>
<td>Baseline surveys of attitudes and awareness</td>
</tr>
<tr>
<td></td>
<td>Local health network pilots</td>
<td>Medium to long term:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Changes to attitudes and awareness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Curriculum changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rates of use of low value services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influence on policy and systems</td>
</tr>
</tbody>
</table>

Foster consumer engagement and acceptance

- Mainstream and social media
- Partnerships with consumer organisations
- Consumer resources
- Features in partner newsletters

Change key clinical practices

- Promotion of the ‘conversation’ and improved shared decision making
- Local pilots

Promote alignment with the healthcare system

- Recruit partners among clinics, hospitals, local and State health regions
- Advocate for incorporation into systems and policy

A clinician-led approach

Choosing Wisely employs a clinician-led process that engages with Australia’s peak medical colleges, societies and associations. In consultation with members, participating organisations develop lists of recommendations for tests, treatments and procedures that evidence shows are low value and should be questioned.

These recommendations are then promoted through organisational channels including member conferences, workshops, and newsletters. The ultimate goal is for incorporation into curriculum, guidelines and professional development programs.

Choosing Wisely Australia membership triples

Six colleges and societies participated in the inaugural Choosing Wisely Australia launch on 29 April 2015, releasing 26 recommendations. As at the end of November 2016, 28 colleges, societies and associations were participating, with a total of 123 recommendations released. The recommendations are diverse and include key themes such as imaging (21% of recommendations), medicine use (20%), pathology (11%), antibiotic use (8%), and end-of-life and palliative care (6%).

Promoting evidence-based care

Most colleges and societies have participated in Choosing Wisely Australia to promote evidence-based care to members and reduce unnecessary tests, treatments and procedures. As a result of their involvement in the Choosing Wisely Australia initiative, 73% of participating colleges and societies are considering how they will work with consumers in the future.

Development, promotion and incorporation of recommendations

Choosing Wisely Australia member organisations and NPS MedicineWise have implemented a range of initiatives to raise awareness of new healthcare recommendations. College and society representatives have anticipated their level of involvement in Choosing Wisely will continue to grow, with over half (63.6%) indicating an anticipated ‘high’ level of involvement within the subsequent 12 months.

As the facilitator of Choosing Wisely Australia, NPS MedicineWise actively supports awareness and implementation of Choosing Wisely principles. One of the Choosing Wisely Australia recommendations from the Royal Australian College of General Practitioners (RACGP) is:

DON'T USE PROTON PUMP INHIBITORS (PPIs) LONG TERM IN PATIENTS WITH UNCOMPPLICATED DISEASE WITHOUT REGULAR ATTEMPTS AT REDUCING DOSE OR CEASING TREATMENT.

In 2015, NPS MedicineWise implemented a general practitioner-focused, multifaceted program that aligned with the goal of this recommendation. The program encouraged stepping down of PPI therapy for maintenance of symptoms in patients with reflux and heartburn.

Key components of the program were:

- an up-to-date, evidence-based summary on the issue sent to GPs
- an online learning module of a clinical case scenario

Tools to implement these clinical decision rules include a booklet, an app, posters and web-based learning modules, which have now been embedded into education programs and routine clinical practice at 15 healthcare services.

“This will improve the safety, appropriateness and efficiency of patient care across our health service. We plan to research the effect of this approach to appropriate imaging education on imaging utilisation and test positivity rates in 2016,” says Professor Stacy Goergen, Director of Research, Monash Imaging, and Adjunct Clinical Professor, Departments of Medical Imaging and Surgery.

“Completion of the web-based education modules will be a prerequisite for our interns and advanced trainees from 2016, to ensure they have the knowledge base to enable them to make wise decisions about imaging referrals. The app will reinforce this training at the bedside.”

CHOOSING WISELY MAKING INROADS WITH HEALTH SERVICES

The Royal Australian and New Zealand College of Radiologists (RANZCR), in support of its six Choosing Wisely Australia recommendations, has developed clinical decision rules to help clinicians, patients, parents and carers come to a shared decision about when imaging may or may not be needed.

Tools to implement these clinical decision rules include a booklet, an app, posters and web-based learning modules, which have now been embedded into education programs and routine clinical practice at 15 healthcare services.

“This will improve the safety, appropriateness and efficiency of patient care across our health service. We plan to research the effect of this approach to appropriate imaging education on imaging utilisation and test positivity rates in 2016,” says Professor Stacy Goergen, Director of Research, Monash Imaging, and Adjunct Clinical Professor, Departments of Medical Imaging and Surgery.

“Completion of the web-based education modules will be a prerequisite for our interns and advanced trainees from 2016, to ensure they have the knowledge base to enable them to make wise decisions about imaging referrals. The app will reinforce this training at the bedside.”

More than a recommendation

- a website knowledge hub on related medicines and conditions
- a patient resource to support conversations between GPs and patients
- an online clinical e-audit for GPs to reflect on their practice
- Pharmaceutical Benefits Scheme feedback distributed to GPs to also reflect on their practice and prescribing patterns.

The Royal Australasian College of Physicians (RACP) is a founding member of Choosing Wisely Australia. RACP has also initiated the EVOLVE program with its affiliated specialty societies, producing lists of recommendations, that are being incorporated into Choosing Wisely Australia.

By the end of November 2016, 13 specialties have published lists on the EVOLVE website (http://evolve.edu.au/) with a further 13 underway. RACP has conducted forums involving 22 specialties on the implications, common themes and learnings arising from developing lists, and strategies to support their translation into clinical practice.

RACP Congress also included sessions on recommendations that have cross-specialty relevance and an interactive workshop to provide input to the development of a general paediatrics list. Posts on low-value care have also been produced by the RACP.

In practice: how members are implementing Choosing Wisely

Survey conducted with founding member colleges and societies (December 2015)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing the list of recommendations</td>
<td>90.9%</td>
</tr>
<tr>
<td>Launch event April 2015</td>
<td>90.9%</td>
</tr>
<tr>
<td>Engaging other colleges/societies</td>
<td>81.8%</td>
</tr>
<tr>
<td>Active promotion to members</td>
<td>81.8%</td>
</tr>
<tr>
<td>Development of member resources</td>
<td>72.7%</td>
</tr>
<tr>
<td>Engagement with social media</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

Dr Gabriel Bletcher and Prof Stacy Goergen

MONASH HEALTH
A community conversation

Effective communication between patients and their health professionals is essential to ensure each individual receives the care most appropriate for them. Choosing Wisely encourages consumers to be active participants in the management of their own care.

Key actions in engaging with consumers include:
- raising awareness through media and social media
- partnering with consumer-related organisations
- development of consumer information and resources.

Strong media interest in Choosing Wisely Australia

Engagement in Choosing Wisely by Australia’s media is one measure of success as we work to promote a national conversation on appropriate care.

Promotional activities generated more than 3,350 news stories featuring Choosing Wisely Australia. This coverage had an estimated reach of over 18 million Australians.

Mainstream media accounted for 92% of coverage. Most coverage was on radio, followed by the internet, television and press. Coverage of the initiative’s recommendations featured on all major radio stations, and in all major newspapers, and the issue of inappropriate healthcare was a subject on such television programs as Catalyst, Four Corners, and Today.

Of the coverage, 86.1% was favourable and 9.6% neutral towards the campaign, with the prominent message that ‘Choosing Wisely Australia could/will result in a reduction of unnecessary health treatments’.

Resources to support improved conversations

5 QUESTIONS

The ‘5 Questions’ resource was developed by Consumer Reports in the United States, and widely adopted internationally, and Choosing Wisely Australia has promoted it to support conversations between clinicians and consumers. It highlights the key questions for consumers to ask their healthcare providers before they get any test, treatment or procedure.

Do I really need this test or procedure?
- What are the risks?
- Are there simpler, safer options?
- What happens if I don’t do anything?
- What are the costs?

This resource has been translated into 10 community languages to support broader uptake within the community.

Consumers as partners

In September 2015, NPS MedicineWise and the Consumers Health Forum of Australia (CHF) jointly hosted the inaugural Choosing Wisely Australia Consumer Roundtable. Thirty representatives from key consumer organisations, community organisations and health professional groups attended. The aim was to raise awareness of the Choosing Wisely initiative and create an opportunity for key stakeholders to provide input to inform our consumer engagement strategy.

In addition we have undertaken focus groups with consumers to ensure our messages are resonating with Australian audiences. Choosing Wisely Australia resources and creative are also tested with consumers.

The Consumers Health Forum and Healthdirect Australia have been supporters of Choosing Wisely Australia since our inaugural launch and have worked closely with NPS MedicineWise to ensure patient interests and communication between clinicians and patients remains central to Choosing Wisely.

A community conversation

Choosing Wisely Australia Report 2016
An initiative of NPS MedicineWise

123 recommendations highlighting healthcare approaches that should be questioned

‘Often consumers don’t have control over their healthcare decisions even though we fund the system and the system is there to serve us. It can be difficult to speak up – Choosing Wisely Australia can help us do that.’

Darlene Cox, presenter at Consumer Roundtable, consumer advocate, Choosing Wisely Australia Advisory Group

A community conversation

Choosing Wisely Australia Report 2016
An initiative of NPS MedicineWise

CONSUMER FACT SHEETS

A consumer portal on the Choosing Wisely Australia website provides links to a range of relevant consumer resources.

VOX POPS

The word on the street

A video project was commissioned to gather community perceptions of health professional and consumer interactions and the opportunities and challenges around having effective conversations. The ‘word on the street’ videos have attracted more than 50,000 views.
Alignment of clinical and healthcare systems

Adopted actions in aligning clinical practice and healthcare systems include:
- promoting the conversation among clinicians and with consumers
- engaging with hospitals and state and local health areas in implementation
- incorporating into systems and health policy.

Choosing Wisely Australia is a catalyst for change and is influencing decision making at a number of levels. This is happening as a result of Choosing Wisely promoting discussions about unnecessary and low-value treatments and tests among health professionals and consumers. Choosing Wisely is also informing tangible policy changes, structures and recommendations through initiatives such as the Department of Health MBS review and The Australian Atlas of Healthcare Variation.

Choosing Wisely Australia is also supporting concrete changes in processes, policies and structures at the clinical coalface that reflect evidence-based recommendations to improve the quality of healthcare for Australians.

These initiatives are helping to build a common vocabulary, ownership by health professionals and a societal-level conversation about appropriate care.

While health services have always undertaken quality improvement and patient safety activities, Choosing Wisely Australia has proven an attractive initiative by grouping a number of these activities in a concerted effort to support change.

Dr Simon Judkins

Without the ‘five questions’, it could have been a disaster

Hunter New England Local Health District in NSW is a keen supporter of Choosing Wisely Australia. At a community meeting, local resident Johnette described how Choosing Wisely had helped her family.

From the age of 11, Johnette’s partner suffered from blood flow issues to his legs, causing skin conditions for which he had all sorts of treatments over the years. Recently his GP had referred him to a vascular surgeon.

The consultation with the surgeon did not start well with another person’s file being referred to and the surgeon describing in vivid terms the procedure that would occur. This made Johnette and her partner confused and worried. Fortunately, Johnette had taken along with her Choosing Wisely’s ‘5 Questions to ask your doctor’, which she had picked up at a community forum run by her health service.

‘When we asked about the risks of surgery the specialist said that surgery has risk factors but he could not be specific,’ Johnette explained.

‘As to safer options, the specialist recommended surgery but suggested compression stockings as an alternative, however this was contrary to previous advice we had received.

And when we asked about cost he was not clear. He told us to go away and think about it and make another appointment in six weeks if we wanted to proceed. The surgeon was clearly annoyed by my questions. We never went back to him. We discussed our situation with our GP and asked for a referral to another surgeon who advised against any surgical intervention due to the severity of scarring to John’s blood vessels. He is under the treatment of a skin specialist, and doing well.

‘Thank God for those five questions, or John’s outcome could have been disastrous.’

John and Johnette

SUPPORTER RESOURCE KIT

A supporter resources kit has been developed for consumer organisations and local health services to help communicate with consumers about the Choosing Wisely Australia initiative.

The kit includes the ‘5 Questions’ resource in a number of formats, presentation slides and videos. Resources are suitable for a range of contexts, including use in patient waiting rooms and community health forums.

‘Choosing Wisely has been a very powerful vehicle to bring all those disciplines in under one big umbrella.’

Dr Simon Judkins, Austin Health
Gold Coast Health is among the first of Australia’s health services to bring together key quality initiatives under the Choosing Wisely banner.

Among a number of tests, treatments and procedures, Gold Coast Health has begun looking at their use of pathology testing across the health service. They have undertaken to assess the current state of pathology utilisation across specialties and service areas, and determine its clinical appropriateness based on current evidence.

They are developing demand-management strategies to improve pathology ordering patterns via guidelines and pathways for activation through education and training. An online dashboard is being developed to support clinical monitoring and auditing of pathology ordering practices.

The ultimate goal is to improve patient safety and experience, while providing high-quality care using the most appropriate pathology tests.

‘We are very excited about our partnership with Choosing Wisely Australia,’ says Jane Hancock, Executive Director Operations at Gold Coast Health.

‘It creates a fabulous opportunity for us to learn and to make an active contribution to a very important national program.

‘Within Gold Coast Health our project is being led by clinicians and is strongly patient/consumer focused. By adopting Choosing Wisely principles, Gold Coast Health is focusing on care that is providing better value for our patients – that is, doing the right test, for the right patient, at the right time, in the right location.’
Learnings and challenges

Choosing Wisely Australia has sought to bring awareness to the issue of the inappropriate use of tests, treatments and procedures.

Key learnings

- Drivers of inappropriate care are multiple and complex.
- Healthcare providers believe they have a responsibility to reduce unnecessary tests, treatments and procedures.
- There is evidence of disconnect between consumer and clinician perceptions of patient expectations. In particular, 41% of GPs felt patients would ask them for unnecessary tests, treatments or procedures several times a week, and 22% said they were asked every day. Only 16% of consumers indicated they ask their healthcare provider for a test.
- Consumers who have heard of Choosing Wisely are more aware that unnecessary tests can be harmful and some tests can produce misleading results that could lead to unnecessary treatment.
- GPs who were aware of Choosing Wisely were more likely to discourage patients from having unnecessary tests, treatments or procedures than those who were not aware of the initiative.
- There is increasing interest from colleges, societies and associations involved in Choosing Wisely to engage with consumers.
- There is a strong appetite from within health services to reduce unnecessary care and reduce risk of harm to patients.

Challenges

- Encouraging member organisations to highlight unnecessary care that is within the control of their specialty.
- Addressing the multiple drivers of unnecessary care and the assumptions that underpin them.
- Measuring the impact of Choosing Wisely.
- Ensuring no consumer groups are disadvantaged by the initiative.

Future directions

We are excited by the opportunities and the challenges that lie ahead for Choosing Wisely Australia. Our priorities include:

- continued focus on partnerships to support conversations about unnecessary care
- embedding Choosing Wisely principles into ‘business as usual’ activities for colleges, societies and associations
- implementation initiatives at a local health services level with both health professionals and consumers
- encouraging consumer participation through partnerships, promotion and supporting resources
- reporting on impact.

Get involved

Choosing Wisely Australia welcomes opportunities to work with interested healthcare organisations to progress the initiative and ensure its success. To find out more or to get involved:

- www.choosingwisely.org.au
- choosingwisely@nps.org.au
- twitter.com/ChooseWiselyAu
- facebook.com/choosingwiselyaustralia
Appendices

Appendix 1

Attitudes and awareness of Choosing Wisely and unnecessary care

Surveys and qualitative research were conducted with general practitioners and specialists in April 2015 (before the launch of Choosing Wisely Australia) and December 2015 (after the launch). Choosing Wisely-related questions were included in a consumer survey in October 2015. The research was designed to provide baseline data to measure the impact of the initiative over time.

AUSTRALIAN HEALTHCARE PROVIDERS

Awareness of Choosing Wisely has increased

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>19%</td>
<td>27%</td>
</tr>
<tr>
<td>December 2015</td>
<td>55%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Healthcare providers agree there is a problem with the use of tests, treatments and procedures

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2015</td>
<td>79%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Healthcare providers feel a responsibility to reduce inappropriate use of tests, treatments and procedures

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2015</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>

“We see about 80-85% of the population every year and we have this continuous relationship with our patients, so we have a unique opportunity to change habits.”

Dr Frank Jones, The Royal Australian College of General Practitioners
Most say they often or always discourage patients from unnecessary tests and treatments

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>69%</td>
<td>57%</td>
</tr>
<tr>
<td>December 2015</td>
<td>73%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Drivers of unnecessary care

<table>
<thead>
<tr>
<th>Reasons</th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient expectations</td>
<td>60%</td>
<td>44%</td>
</tr>
<tr>
<td>Potential for medical litigation</td>
<td>58%</td>
<td>41%</td>
</tr>
<tr>
<td>Uncertainty regarding the diagnosis</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Difficulties in accessing information from doctors in other settings, including results</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>Patient referred specifically for the test, treatment or procedure</td>
<td>32%</td>
<td>34%</td>
</tr>
<tr>
<td>The need to keep patients engaged</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Taking the approach that it is better to test than not to test</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>The recommended test, treatment or procedure is unavailable</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Healthcare providers say patients regularly ask for unnecessary tests

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several times a week</td>
<td>41%</td>
<td>21%</td>
</tr>
<tr>
<td>Every day</td>
<td>22%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Healthcare providers welcome consumer questions using the Choosing Wisely ‘5 Questions to ask your doctor or other healthcare provider’ but time can be a key barrier

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and no barriers</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Time as a barrier</td>
<td>44%</td>
<td>36%</td>
</tr>
</tbody>
</table>

Small numbers of respondents highlighted additional barriers such as:
- patient inability to understand reasons for decision and risk/benefit
- difficulties in answering questions on cost and effectiveness
- perception of mistrust
- patient expectations
- patient health literacy and language barriers
- cost for the patient (longer consultation)
- difficulty advising against other health providers who recommended tests.

AUSTRALIAN CONSUMERS
Growing consumer awareness of Choosing Wisely

Efforts to increase consumer awareness of Choosing Wisely Australia have been growing steadily since implementation of the initiative in April. In August 2015, Australian consumers were surveyed for the first time about Choosing Wisely Australia. 5% of consumers surveyed were aware of Choosing Wisely Australia.

Those consumers aware of Choosing Wisely were more likely to have had a recent medical test and be between 16 and 34 years of age.

<table>
<thead>
<tr>
<th></th>
<th>Aware of Choosing Wisely</th>
<th>General population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had a medical test</td>
<td>69%</td>
<td>45%</td>
</tr>
<tr>
<td>Age 16-34</td>
<td>62%</td>
<td>34%</td>
</tr>
</tbody>
</table>
Why consumers have tests

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare provider recommended it</td>
<td>79%</td>
</tr>
<tr>
<td>Consumer asked for it</td>
<td>16%</td>
</tr>
</tbody>
</table>

Older consumers were also less likely to ask for medical tests.

An awareness of risks of unnecessary tests and treatments

Agree with reducing unnecessary care but...

While 71% of consumers agreed with the concept of reducing unnecessary tests, 74% indicated that if they were sick, their doctor should conduct all available medical tests related to their condition.

<table>
<thead>
<tr>
<th>Agree with reducing unnecessary care</th>
<th>Choosing Wisely</th>
<th>General population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>71%</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Aware of Choosing Wisely

<table>
<thead>
<tr>
<th>Agree that some tests can produce misleading results and lead to unnecessary treatment</th>
<th>Choosing Wisely</th>
<th>General population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55%</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>45%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Aware of Choosing Wisely

<table>
<thead>
<tr>
<th>Agree that having a medical test when not needed can be harmful</th>
<th>Choosing Wisely</th>
<th>General population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>47%</td>
<td>67%</td>
</tr>
</tbody>
</table>

‘...I think there is a bit of a trend of sometimes over prescribing at times. And the idea that somehow preventative measures might be the best course of action. Sometimes doing nothing could be the best course.’

Consumer vox pop interview participant

Consumers feel confident in asking questions about medical tests and being proactive in their healthcare

<table>
<thead>
<tr>
<th>Confident in asking questions</th>
<th>89%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking an active role in healthcare</td>
<td>90%</td>
</tr>
</tbody>
</table>

‘Because I want to know what I’m taking, what I am diagnosed with, what the side effects are.’

Consumer vox pop interview participant

1 - April 2015 surveys were responded to by 554 randomly selected GPs and 435 randomly selected medical specialists. Surveys were also promoted by colleges and societies. December 2015 surveys were responded to by 406 GPs and 337 specialists.

2 - Choosing Wisely related questions were included in the NPS MedicineWise National Consumer Survey which was responded to by 2581 consumers.

3 - Medical test was defined as including laboratory tests (eg blood tests) or imaging tests (eg X-rays and CT scans).
Appendix 2
Choosing Wisely Australia Advisory Group

- Associate Professor Richard King, AM, Senior Medical Director, Monash Health
- Professor Meera Agar, Director of Palliative Care, Braeside Hospital, HammondCare
- Dr Matthew Anstey, Staff Specialist Intensive Care Physician, Princess Margaret Hospital
- Melissa Cadzow, Consumer Representative
- Darlene Cox, Executive Director, Health Care Consumers’ Association, Consumer Representative
- Associate Professor Adam Elshaug, Health Care Policy, Menzies School of Public Health
- Dr Rob Hosking, General Practitioner, The Elms Family Medical Centre
- Elizabeth Koff, Secretary, NSW Health (to June 2016)
- Sally Marotti, Intensive Care Specialist Pharmacist, The Queen Elizabeth Hospital
- Professor John Slavotinek, Consultant Radiologist, Repatriation General Hospital, Flinders Medical Centre

Appendix 3
Choosing Wisely Australia members and supporters (April 2015 – November 2016)

FOUNDRING MEMBERS:
- Australasian College for Emergency Medicine (ACEM)
- Australasian Society of Clinical Immunology and Allergy (ASCIA)
- The royal Australian and New Zealand College of Radiologists (RANZCR)
- The royal Australian College of General Practitioners (RACGP)
- The Royal Australasian College of Physicians (RACP)
- The Royal College of Pathologists of Australasia (RCPA)

1. Austin Health
2. Australasian Chapter of Sexual Health Medicine
3. Australasian College for Emergency Medicine
4. Australasian Society for Infectious Diseases
5. Australasian Society of Clinical Immunology and Allergy
6. Australian and New Zealand Association of Neurologists
7. Australian and New Zealand College of Anaesthetists
8. Australian and New Zealand Intensive Care Society
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9. Australian and New Zealand Society for Geriatric Medicine
10. Australian and New Zealand Society of Palliative Medicine
11. Australasian Chapter of Palliative Medicine
12. Australian College of Nursing
13. College of Intensive Care Medicine of Australia and New Zealand
14. Consumers Health Forum of Australia
15. Gastroenterological Society of Australia
16. Gold Coast Health
17. Haematology Society of Australia and New Zealand
18. Healthdirect Australia
19. Human Genetics Society of Australasia
20. Monash Health
21. Royal Adelaide Hospital
22. Royal Australasian College of Surgeons
23. Royal Brisbane and Women’s Hospital
24. Royal Perth Hospital
25. Sir Charles Gairdner Osborne Park Health Care Group
26. The Australasian College of Dermatologists
27. The Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists
28. The Australian Physiotherapy Association
29. The Endocrine Society of Australia
30. The Royal Australasian College of Physicians
31. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
32. The Royal Australian and New Zealand College of Ophthalmologists
33. The Royal Australian and New Zealand College of Radiologists
34. The Royal Australian College of General Practitioners
35. The Royal College of Pathologists of Australasia
36. The Society of Hospital Pharmacists of Australia