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Governance of External Doctors' Health Programs

Australian Health Practitioner Regulation Agency on Behalf of the Medical Board of Australia

CONTENTS

1. ACRONYMS AND DEFINED TERMS

The following terms are used in this report:

Board means the Medical Board of Australia,

Doctor means a person who is registered under the National Law in the medical profession.

External doctors' health organisation means an organisation that is dedicated to supporting doctors and medical students to access quality medical care and that operates independently of regulatory authorities.

External doctors' health program means a health program offered to doctors and medical students by an external doctors' health organisation.

Health practitioner has the same meaning as in the National Law.

Medical practitioner has the same meaning as in the National Law.

Medical professional means a medical practitioner or student, as defined in the National Law.

Medical student means a person whose name is entered in a register kept under section 229 of the National Law by the Board.

National Law means the Health Practitioner Regulation National Law as set out in the Schedule to the *Health Practitioner Regulation National Law Act 2009* (Qld) and applied as a law of each participating jurisdiction.

Network means the Australasian Doctors' Health Network.

Lead jurisdictions means jurisdictions in which we recommend external doctors' health organisations are funded by the Board to provide services in neighbouring jurisdictions.

Supported jurisdictions means jurisdictions in which we recommend Board-funded services are provided by organisations located in neighbouring jurisdictions.

The following acronyms are used in this report:

ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMSA	Australian Medical Students' Association
BMA	British Medical Association
CAMP	Case management, aftercare and monitoring program run by the VDHP
CLG	Company limited by guarantee
CPHN	Canadian Physician Health Network
FSPHP	Federation of State Physician Health Programs

GMC	General Medical Council
GP	General practitioner
GPRA	General Practice Registrars Australia
NHS	National Health Service
NRAS	National Regulation and Accreditation Scheme
NSW	New South Wales
NT	Northern Territory
PHP	Practitioner Health Programme
Qld	Queensland
SA	South Australia
UK	United Kingdom
USA	United States of America
VDHP	Victorian Doctors' Health Program
WA	Western Australia

2. EXECUTIVE SUMMARY

Organisations dedicated to supporting doctors and medical students (collectively, referred to in this report as medical professionals) to access quality medical care have been established in all Australian States and Territories except Tasmania and the Northern Territory (**"NT"**).

The structure of these organisations, which are operationally independent of the Australian Health Practitioner Regulation Agency (**"AHPRA"**) and the Medical Board of Australia (**"Board"**) varies, but all have the basic objective of providing a point of contact to facilitate access to the health care system by doctors and medical students.

In this report we emphasise the operational independence of these organisations from AHPRA and the Board by referring to them as 'external doctors' health organisations' and to the programs they offer as 'external doctors' health programs'.

External doctors' health organisations and programs are mostly run by volunteers, with significant support in some jurisdictions from branches of the Australian Medical Association (**"AMA"**). In Victoria and South Australia (**"SA"**) State medical boards also provided significant funding prior to the introduction of the National Registration and Accreditation Scheme for health practitioners (**"NRAS"**) in July 2010.

In 2013, following representation from the Australian Health Workforce Ministerial Council, the Board decided to provide funding for external doctors' health programs. It has continued to provide some funding for existing programs pending development of a sustainable national arrangement.

This report was commissioned by the Board and provides advice on structural, service and contractual arrangements to underpin the Board's funding of external doctors' health programs. In preparing this report, DLA Piper undertook a broad consultation and review process.

The Board's functions in respect of external doctors' health programs are defined by, and must be exercised having regard to the objectives and guiding principles set out in, the National Law. The recommendations of this report take into account the need to ensure external doctors' health programs do not, and are not perceived to, impair appropriate regulatory action by the Board.

Consultation with a range of stakeholders confirmed the current need for programs dedicated to the health and wellbeing of medical professionals. It was suggested that demand for services from certain groups of medical professionals is growing and there is a need for more resources to implement appropriate preventive and remedial strategies, although some programs also reported a reduction in presentations in recent years, which some attribute to the mandatory notification provisions introduced into the legislative framework in 2010.

The report contains a description of the range of services currently provided through the six established external doctors' health programs and the organisational arrangements in place. It also describes the very strong commitment expressed by stakeholders to the existing jurisdiction-based organisational model, based on the belief that the local standing of program leaders, the respect with which they are regarded within their local medical communities and their knowledge of local service systems are all critical to the sustainability and effectiveness of external doctors' health programs.

We propose a number of principles to underpin the Board's approach to organisational and program support, based on the objectives of protecting the public, promoting accountability, transparency, efficiency, effectiveness and fairness and supporting medical professionals to take personal and professional responsibility for their health.

We have analysed the services currently provided by external doctors' health programs in Australia and in other relevant jurisdictions and recommend a suite of core services to be provided in all Australian jurisdictions, encompassing advice and referral, education and awareness, administration and general advocacy.

We have noted the Board's objective of achieving equity of access to services for medical professionals in all jurisdictions, the good clinical outcomes reported by Victorian Doctors' Health Program (**"VDHP"**) and the clear support in comparable internationals settings for case management approaches for medical professionals with drug, alcohol or mental health problems. We have also noted the Board's concern to ensure that case management programs do not displace its proper regulatory role. On balance, we recommend continued funding of the VDHP case management program for three years, to enable a detailed evaluation of experience in Victoria and in other jurisdictions in which such programs have not been offered. The objective would be to establish whether there is system-level evidence of the expected outcomes of the Victorian case management program such as earlier presentation of ill doctors, better therapeutic success rates and improved public safety. If such outcomes are confirmed, we recommend the Board considers funding of case management and related services across all jurisdictions.

If the Board decides not to fund case management programs, we see no barrier in principle to such programs being conducted by external doctors' health organisations utilising alternative sources of funding, but we believe it will be extremely difficult if not impossible for funding to be sourced at sufficient levels to ensure service sustainability and equity.

We were impressed with the quality of general practice services established in SA, but in the context of limited resources and the availability of alternative services, we recommend that the Board funds external doctors' health organisations to provide education and network development activities that enable medical professionals to routinely access experienced general practitioners (**"GPs"**) working in established general practices, as an alternative to funding development of stand-alone services.

The relatively small overall size of the service system favours a single national provider with service delivery tailored to the specific needs of each jurisdiction. This would be our recommendation in the absence of established organisations with substantial engagement of medical leaders in six jurisdictions. There was a strong preference by these organisations and the medical professionals engaged in their leadership for a continuing multi-organisational network, enabling management and governance to remain closely integrated with service delivery locally. Although the compliance costs and complexity of this arrangement are likely to be higher than those that would be incurred with a single national provider, we have concluded that the best approach to maintain this critically-important engagement is to support the existing organisations and to formalise the structure and roles of the Australasian Doctors' Health Network (**"Network"**) to enable national coordination and standardisation of service provision where possible. Higher compliance costs will be offset to some extent by the continuing volunteer input of a significant number of medical professionals in all jurisdictions.

We recommend that services in the smaller jurisdictions are supported organisationally from adjacent jurisdictions by formally allocating responsibility and funding to organisations in NSW, Victoria and SA for service provision in the ACT, Tasmania and the NT respectively. The ACT service is already in place, is highly valued and should be supported, rather than replaced, by the NSW organisation. We also recommend that the Network is allocated responsibility for providing a number of shared services that can be provided efficiently and effectively from a national base.

We have provided advice about the appropriate organisational structures that will support this service system configuration.

To the extent that they were accounted for, we have analysed the costs of existing service provision by all external doctors' health organisations and developed a funding model for provision of the recommended suite of core services in all jurisdictions and case management services for an initial period in Victoria, together with funding models that would apply if case management services were available in all or no jurisdictions.

Recognising the potential for actual or perceived conflicts between the regulatory role of the Board and the health and wellbeing roles of Board-funded external doctors' health organisations, we have outlined the clinical governance and compliance obligations that will need to be implemented to ensure Board and public confidence in external doctors' health programs, particularly if they deliver case management and related services. In particular, we recommend development of a national Board-approved clinical governance framework including protocols for decision-making about entry to case management programs and at critical points in the management pathway, and a national performance framework to guide reporting to the Board. Further, we recommend a binding protocol detailing communication obligations of all parties is incorporated into the agreements between the Board and funded organisations.

We have provided an overview of the type and contents of agreements between the Board and external doctors' health programs. The complexity and administrative burden of a multi-organisational service system will need to be reduced by standardising agreements between the Board and each funded organisation. We also recommend that organisations report to the Board via the Network, to streamline reporting arrangements and allow collation and analysis of performance information, with exception reporting direct to the Board.

3. RECOMMENDATIONS

Principles

Recommendation 1

That the Board adopts the principles proposed in this report as the basis for its support of external doctors' health programs.

Services

Recommendation 2

That the Board funds the provision in all jurisdictions of a standard suite of core services for medical professionals, including advice and referral, education and awareness, administration and general advocacy.

Recommendation 3

That the Board:

- funds the continuing provision of case management and related services by the VDHP for a period of three years;
- commissions an independent evaluation to determine whether the availability of those services achieves the expected outcomes of earlier presentations, better therapeutic success rates and improved public safety; and
- when the outcomes of that evaluation are available, reconsiders the costs and benefits of funding equivalent services in all jurisdictions.

Recommendation 4

That the Board notes that while there is no barrier in principle to external doctors' health programs providing case management and related services funded from non-Board sources if the Board decides not to fund those services, the availability of funding is likely to be limited and the sustainability of services is therefore likely to be very uncertain under such circumstances.

Recommendation 5

That because of very high establishment and operating costs the Board does not fund general practices dedicated to the care of medical professionals, but instead supports external doctors' health programs to provide education and network development activities that enable medical professionals to routinely access experienced GPs working in established general practices.

Recommendation 6

That when the outcomes of the BMA/GMC pilot program are available, the Board further considers whether peer support should be included in the suite of funded services and if so, the appropriate scope of such services.

System design and organisational structures

Recommendation 7

That the Board funds the delivery of external doctors' health programs through a national service system based on the existing doctors' health organisations in NSW, Queensland, SA, Victoria and WA, with:

- NSW invited to assume organisational responsibility for services in the ACT;
- SA invited to assume organisational responsibility for services in the NT;
- Victoria invited to assume organisational responsibility for services in Tasmania; and
- all organisations maintaining their not-for-profit status.

Recommendation 8

That the Board funds the Network to assume the ongoing leadership, advocacy, capacity-building and support roles defined in this report.

Recommendation 9

That as a condition of funding, the Board requires the Network and all organisations that deliver Board-funded external doctors' health programs to incorporate, with a preference for a company limited by guarantee structure.

Recommendation 10

That membership of organisations that provide external doctors' health programs is open to individuals and relevant professional organisations, but that AHPRA is not a member of any organisation.

Recommendation 11

That membership of the Network is open to the incorporated jurisdictional doctors' health programs and other interested organisations (including, for example, the AMA, AMSA, the professional colleges and other professional groups).

Recommendation 12

That the Board requires organisations that deliver Board-funded doctors' health programs, and the Network, to establish:

- skills-based, volunteer boards of governance of between five and nine directors, including a meaningful quota of directors on each board who are not health professionals and at least one director on each Board who has expertise in community advocacy; and
- appropriate mechanisms to protect directors and officers from liability.

Recommendation 13

That directors of external doctors' health programs and the Network are not remunerated, but that their reasonable expenses, including professional development expenses, are supported.

Funding

Recommendation 14

That the Board:

- funds external doctors' health programs for the first three years in accordance with the distribution presented in Table 13 of this report to a total of $1.7 million in year one with an appropriate escalation for inflation in subsequent years; and
- notes the higher cost of providing case management and related services to all jurisdictions in the future.

Managing potential conflicts

Recommendation 15

That the Board:

- requests the Network to develop a national clinical governance framework that meets the specifications defined in this report;
- requires implementation of the framework as a condition of funding of external doctors' health programs; and
- as a condition of funding, requires organisations to seek its consent before providing additional services not funded by the Board, such consent to not be withheld unreasonably.

Recommendation 16

That a protocol detailing the communication obligations of the Board and external doctors' health programs is developed and included in the agreements between the relevant parties.

Recommendation 17

That the Board requires external doctors' health programs to refer individuals seeking specific advice about the National Law to their own legal advisers and/or indemnity insurers.

Agreements and reporting arrangements

Recommendation 18

That the Board enters into standardised three-year funding and service agreements with each external doctors' health organisation, defining mutual obligations and incorporating a national clinical governance framework, a national performance framework and a protocol defining expectations of communication between the Board and each program.

Recommendation 19

That the primary reporting relationship of external doctors' health programs to the Board is via the Network, in accordance with an agreed performance framework, but that reporting is also required direct to the Board in the circumstances identified in this report.

Recommendation 20

That Board personnel meet at least annually with the board of the Network to exchange relevant program information and discuss program effectiveness and safety (within the constraints of confidentiality and privacy).

4. BACKGROUND TO THIS PROJECT

Organisations dedicated to supporting doctors and medical students to access quality medical care have been established in all Australian States and Territories except Tasmania and the NT.

In this report we emphasise the operational independence of these organisations from AHPRA and the Board by referring to them as 'external doctors' health organisations' and to the programs they offer as 'external doctors' health programs'.

The structure of these organisations and the programs they offer vary across jurisdiction, but all have the basic objective of providing a point of contact to facilitate access to the health care system by doctors and medical students.

Historically, all external doctors' health organisations have relied on volunteer doctors to deliver programs and/or for organisational leadership. Some have received significant in-kind support from state branches of the AMA and other donors and sponsors such as medical societies, medical indemnity insurers and pharmaceutical companies.

Before the introduction of NRAS in July 2010, the State medical boards in Victoria and SA also funded doctors' health programs in those States. From 1 July 2010, State and Territory medical boards were abolished, AHPRA was established and the Board assumed responsibility for regulating all medical practitioners and students in Australia. AHPRA administers NRAS and provides administrative support to the Board and other national boards[1].

In late 2011, the Australian Health Workforce Ministerial Council asked the Board to continue the financial support previously provided to the VDHP by the former Medical Board of Victoria, and consider expanding the program nationally. The Board consulted widely on this issue. There was general support for the Board to fund external doctors' health programs but little support for an increase in registration fees to pay for those programs. There was also a lack of consensus on:

- the range of services that should be offered by external doctors' health programs; and
- the appropriate configuration of the service system.

In 2013 the Board decided to fund external doctors' health programs in Australia. It has provided some funding for existing programs pending development of a sustainable national arrangement.

On behalf of the Board, AHPRA commissioned DLA Piper to advise on the following matters:

- The organisational structure/s for external doctors' health programs.
- Minimum services that health program/s should provide.
- A fair and equitable funding model for each proposed organisational model.
- The type of agreement (e.g. contract, memorandum of understanding etc.) that AHPRA, on behalf of the Board should enter into with the external doctors' health program/s and what elements the agreement should include, including the definition of accountabilities for the external doctors' health program/s.

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[1] The relationship between the Board and AHPRA is governed by a "Health Profession Agreement" which defines the services to be provided by AHPRA to the Board to enable it to carry out its functions, the fees payable by health practitioners and the annual budget of the Board. AHPRA employs all staff and supports the Board by providing administrative assistance and policy advice and entering into contracts with external providers.

- Options for the reporting relationships between the Board/AHPRA and the external doctors' health program/s.
- How the proposed organisational, governance and accountability arrangements address any real or perceived community concerns about the conflict between the Board's regulatory role to protect the public and the funding.

In commissioning this project, AHPRA emphasised the need for:

- clear delineation between the regulatory role of the Board in managing impaired medical professionals and the role of external doctors' health programs in supporting medical professionals and promoting their health; and
- equitable access for all medical professionals.

In developing the structure and funding options requested by the Board, DLA Piper:

- reviewed the relevant legislation;
- undertook a high level review of the national and international literature relating to doctors' health and doctors' health programs;
- consulted with:
    - the leaders of all doctors health programs in Australia;
    - other senior health practitioners with an interest and experience in doctors' health and doctors' health programs;
    - representatives of the Australian Medical Students' Association (**"AMSA"**);
    - the AMA, at both national and jurisdictional levels;
    - representatives of the Board; and
- convened a workshop with the Network.

Mr Michael Rhook assisted with the development of funding options.

This report describes the process undertaken by DLA Piper, and its recommendations.

5. THE REGULATORY CONTEXT

5.1 Functions of the Board

The *Health Practitioner Regulation National Law* as in force in each State and Territory (**"National Law"**) establishes the NRAS and the Board.

The National Law sets out the objectives of the NRAS, which include:

> *"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."*[2]

The National Law also sets out guiding principles for the NRAS as follows[3] —

> *"(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;*
>
> *(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;*
>
> *(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality."*

Any entity exercising functions under the National Law is required to exercise those functions having regard to the objectives and guiding principles of the NRAS set out in the Act.[4]

Section 35(1) of the National Law sets out the functions of the Board, which include:

- registering medical professionals;
- developing standards, codes and guidelines for the medical profession;
- investigating notifications and complaints; and
- where necessary, conducting panel hearings and referring serious matters to Tribunal hearings.

The National Law establishes a range of registration categories under which a doctor can practise medicine in Australia. The Board can also grant student registration to medical students undertaking an approved program of study. The Board has power to check an applicant's identity[5] and criminal history[6] and/or investigate an applicant[7] and may refuse, suspend or impose conditions on registration and accept undertakings from registrants[8].

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2 Section 3(2)(a), Health Practitioner Regulation National Law.

3 Section 3(3), Health Practitioner Regulation National Law.

4 Section 4, Health Practitioner Regulation National Law.

5 Section 78, Health Practitioner Regulation National Law.

6 Section 79, Health Practitioner Regulation National Law.

7 Section 80(1)(a), Health Practitioner Regulation National Law.

8 Section 156, Health Practitioner Regulation National Law.

Board functions in relation to medical professionals with health concerns

In addition to its regulatory role, the Board's functions under section 35(2) also include:

> *"at the Board's discretion, to provide financial or other support for health programs for registered health practitioners and students".*[9]

'Health program' is defined in the National Law to mean:

> *"a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence."*[10]

The Board's functions in respect of external doctors' health programs are therefore defined by the National Law and must be exercised having regard to the objectives and guiding principles set out above.

In performing its regulatory functions with respect to the NRAS, the Board is required to take into account impairment or other health issues affecting medical professionals. Impairment is defined in the National Law as follows:

> *"**Impairment**, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect—*
>
> *(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or*
>
> *(b) for a student, the student's capacity to undertake clinical training—*
>
> *(i) as part of the approved program of study in which the student is enrolled; or*
>
> *(ii) arranged by an education provider."*[11]

In particular:

- The Board may decide an individual is not a suitable person to be registered as a medical practitioner if in its opinion, "the individual has an impairment that would detrimentally affect the individual's capacity to practise the profession to such an extent that it would or may place the safety of the public at risk"[12].
- A registered medical practitioner who applies to renew his or her registration must complete a statement that includes a declaration that he or she does not have an impairment[13].
- Registered medical practitioners and medical students are required to notify the Board within 7 days after becoming aware of a relevant event, including if the practitioner's right

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9 Section 35(1)(n), Health Practitioner Regulation National Law.

10 Section 5, Health Practitioner Regulation National Law.

11 Section 5, Health Practitioner Regulation National Law.

12 Section 55(1)(a), Health Practitioner Regulation National Law.

13 Section 109(1)(a)(i), Health Practitioner Regulation National Law.

to practise at a hospital or another facility at which health services are provided is withdrawn or restricted because of the practitioner's health[14].

- The Board may investigate a registered medical practitioner or medical student registered by the Board if it decides it is necessary or appropriate because the Board has received a notification or for any reason believes the practitioner or student has or may have an impairment[15].
- The Board may take immediate action in relation a medical practitioner's or medical student's registration if it reasonably believes that because of the practitioner's performance, health or conduct, or because of the student's impairment, the practitioner or student poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety[16].

It should be noted that the terms 'illness' and 'impairment' are not synonymous. Illness is the term used to describe the existence of a physical or psychiatric disease state and can include addictive disease, injury and cognitive change. In relation to medical professionals, impairment as defined in the National Law only exists if an illness detrimentally affects or is likely to detrimentally affect a medical practitioner's capacity to practise his or her profession or a medical student's capacity to undertake clinical training.

5.2 Mandatory notification of notifiable conduct

The Board's regulatory role is supported by provisions in the National Law that require health practitioners, as soon as practicable after forming a reasonable belief in the course of practising their profession that a medical practitioner has engaged in notifiable conduct or a medical student has an impairment that in the course of the student undertaking clinical training may place the public at substantial risk of harm, to notify AHPRA[17].

'Notifiable conduct' is defined for this purpose as follows:

> *"**Notifiable conduct**, in relation to a registered health practitioner, means the practitioner has—*
>
> *(a) practised the practitioner's profession while intoxicated by alcohol or drugs; or […]*
>
> (c) *placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment."*[18]

Division 3 of Part 8 also establishes provisions for voluntary notification on the grounds that a registered medical practitioner or medical student has, or may have, an impairment. This Division does not require the notifier to form a reasonable belief that the public may be at risk of harm.

The Board has broad powers to respond to notifications received about the health of registered medical practitioners and medical students.

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14 Section 130, Health Practitioner Regulation National Law.

15 Section 160(1), Health Practitioner Regulation National Law.

16 Section 156(1), Health Practitioner Regulation National Law.

17 Section 141, Health Practitioner Regulation National Law.

18 Section 5, Health Practitioner Regulation National Law.

Two States have created exceptions to the mandatory notification obligation for health practitioners who form a reasonable belief that there has been notifiable conduct when treating other health practitioners:

- In Western Australia ("**WA**"), the mandatory notification obligation does not apply to a health practitioner who forms the reasonable belief in the course of providing health services to another health practitioner[19].
- In Queensland, the mandatory notification obligation is subject to an amendment which will commence on a day to be fixed by proclamation[20]. When the amendment commences, a health practitioner who forms the reasonable belief as a result of providing a health service to another health practitioner will not be subject to a mandatory notification obligation, although this exception will only apply where the health practitioner reasonably believes that the notifiable conduct relates to an impairment which will not place the public at substantial risk of harm and is not professional misconduct.

Registered health practitioners in all jurisdictions are also exempt from the requirement to make a mandatory notification in certain other circumstances, which are listed in s. 141 of the National Law[21].

5.3 Implications for Board funding of external doctors' health programs

It is clear that there is potential for tensions to arise between the Board's regulatory functions, particularly as they relate to medical professionals who have an impairment, and its function of supporting external doctors' health programs.

In particular the regulatory role of the Board, supported by the mandatory notification obligation imposed on treating doctors in the majority of States and Territories, has the potential to impede the effectiveness of external doctors' health programs, by deterring medical professionals with health problems from using those programs. Further, public confidence in the integrity of the Board's regulatory approach could be undermined if there is any perception that the Board supports independent organisations to provide health services to medical professionals who should be, but are not, under the Board's regulatory supervision.

Breen noted that prior to the introduction of the National Law, reporting was required in Victoria only if an impaired doctor continued to practise against advice, whereas the National Law is worded in the past tense so that no exception can be made for an impaired doctor who seeks help and voluntarily ceases to practise while receiving care[22]. He described the notification provisions in the National Law as highly regressive and likely to deter doctors from seeking help.

The VDHP has reported, however, that despite initial anxieties that mandatory reporting requirements would make doctors and medical students less likely to seek help, there has been no significant change to the number or nature of contacts both by phone and in person[23].

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19 *Health Practitioner National Law (WA) Act 2010*, s. 5(7)

20 *Health Ombudsman Act 2013* Part 23, s. 326.

21 See the Board's "Guidelines for mandatory notifications" published at www.medicalboard.gov.au.

22 Breen K. Doctors' health: can we do better under national registration? Med J Aust 2011; 194 (4): 191.

23 Jenkins, K & Dunkley, K. Will I be reported for seeking help? Vicdoc March 2011: 31.

Others argue that if impaired doctors feel deterred by mandatory reporting laws, "we are entitled to conclude that there was, and continues to be, significant non-compliance with the ethical obligations that arguments against mandatory reporting depend on"[24].

This issue underpins a number of the issues discussed below in relation to the service model and governance of external doctors' health programs.

[24] Parker M. Mandatory reporting, doctors' health and ethical obligations. Med J Aust 2011; 194 (4): 205.

6. EXTERNAL DOCTORS' HEALTH PROGRAMS

6.1 Rationale for external doctors' health programs

> *"The physician who doctors himself has a fool for a patient."*
>
> Sir William Osler, 1849-1919

At 30 September 2011 there were 87,790 doctors registered in Australia, with 73,980 working as clinicians[25]. In 2010, there were 15,397 medical students in Australia[26].

The composition of the medical professional workforce in Australia is further discussed at Attachment 1.

Doctors who manage their own health and wellbeing appropriately have a greater prospect of positively influencing the health behaviours of their patients[27]. Doctors who suffer ill health may progress to impairment as defined in the National Law, which by definition means there is some actual or potential detrimental effect on their capacity to practice their profession.

While doctors suffer from the same range of health issues as the general community[28], they have also been shown to be physically healthier than the average person in the community. Various studies conducted in the United Kingdom and Australia have found the standardised mortality of doctors to be low, an outcome often attributed to the generally high socio-economic status and high education status of doctors[29] [30] [31].

It is widely believed, however, that workplace practices and common personal characteristics predispose medical professionals to specific health and wellbeing risks. A high prevalence of psychological distress has repeatedly been reported amongst medical professionals, often attributed to the demanding nature of medical practice and the often obsessive, conscientious and committed personalities of medical professionals. The correlation of psychological distress with diagnosed mental illness, however, is not entirely clear.

The rate of drug misuse by doctors is reported to be the same as that of the general population, but because they have access to prescription drugs, doctors are more likely to misuse them[32] .

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25 AIHW 2013. Medical workforce 2011. National health workforce series. Cat. no. HWL 49. Canberra: AIHW.

26 Health Workforce Australia 2012, Australia's Heath Workforce Series - Doctors in focus, Health Workforce Australia: Adelaide.

27 Oberg EB, Frank E. Physicians' health practices strongly influence patient health practices. J R Coll Physicians (Edinb) 2009;39(4):290-1.

28 Kay M, Mitchell G, Del Mar C. Doctors do not adequately look after their own physical health. Medical Journal of Australia 2004;181(7):368-370.

29 Carpenter L, Swerdlow A, Fear N. Mortality of doctors in different specialties: findings from a cohort of 20,000 NHS consultants. OccupEnviron Med1997; 54: 388-395.

30 Schlicht SM, Gordon IR, Ball JR, Christie DG. Suicide and related deaths in Victorian doctors. Med J Aust1990; 153: 518-521.

31 Clode, D. (2004) The Conspiracy of Silence: Emotional health among medical practitioners, Royal Australian College of General Practitioners, South Melbourne.

32 Wolters Kluwer Health: Lippincott Williams & Wilkins (2013, October 4). "Self-medication": Why doctors abuse prescription drugs. ScienceDaily. Retrieved January 17, 2014, from http://www.sciencedaily.com/releases/2013/10/131004124937.htm.

While it is difficult to make a compelling case for the provision of external doctors' health services on the basis of the health status of the medical profession, the main issue of concern is the difficulty medical professionals experience accessing health care. The case for developing more accessible services is strengthened by the fact that doctors' health practices strongly influence patients' health practices (see footnote 27 above).

Professional colleges[33] [34] [35] and other professional and regulatory bodies[36] [37] encourage doctors to have their own GP, but a number of surveys have confirmed that a significant proportion of medical professionals do not have an established therapeutic relationship with a GP and/or do not always seek advice when they are unwell[38] [39] [40].

A framework describing the barriers to health care access experienced by GP respondents to a survey is reproduced below (Table 1). A more detailed discussion about the health and health-seeking behaviour of medical professionals is included in Attachment 2.

33 Royal Australasian College of Physicians. Health of doctors. Position statement, May 2013 accessed on 26 December 2013 at http://www.racp.edu.au/page/afoemevent&eventid=16AC340C-0314-0503-705319B51C4EB671.

34 Anaesthesia Continuing Education Coordinating Committee. Welfare of Anaesthetists Special Interest Group. Personal Health Issues and Strategies. Accessed on 1 January 2014 at http://www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists/introduction.html#resources.

35 Royal Australasian College of Surgeons. Surgical Competence and Performance. A guide to aid the assessment and development of surgeons.

36 Australian Medical Association. Health and wellbeing of doctors and medical students – 2011 accessed on 26 December 2013 at https://ama.com.au/node/6551.

37 Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australian accessed on 2 January 2014 at http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

38 Markwell A and Wainer Z. The health and wellbeing of junior doctors: insights from a national survey. Med J Aust 2009 Oct 19;191(8):441-4.

39 Davidson S. and Schattner P. Doctors' health-seeking behaviour: a questionnaire survey. MJA 2003; 179: 302–305.

40 Hillis J. et. al. Painting the picture: Australasian medical student views on wellbeing teaching and support services. Med J Aust. 2010 Feb 15;192(4):188-90.

Table 1: Examples of health access barriers for GPs[41]

Patient barriers	
No GP	Difficult to choose GP Difficult if no rapport
Lack of time	Concern about inconvenience for their patients Concern about inconvenience for self Failure to prioritise time
Trivialising illness	Never get "sick enough" Don't want to waste GP's time
Mental health issues	Embarrassing More concern about confidentiality GP may not be best option for care
Provider barriers	
Poor quality care	Authoritarian approach Poor communication Over investigation Negative experience
Lack of confidentiality	Professional gossip
	Aware of others breaching confidentiality
	More difficult with practice partner
Professional barriers	
Corridor consultations	More convenient to consult a medical friend
Self-care and health literacy	Reduced need for health care because healthy Already good with preventive health care Effective self-care/treatment Awareness of negative consequences of documentation of illness

Source: Kay M. et. al. Developing a framework for understanding doctors' health access: a qualitative study of Australian GPs. Australian Journal of Primary Health 2012;18:158-165.

6.2 Characteristics of external doctors' health programs and other services

To address concerns about the barriers medical professionals experience in accessing health care, external doctors' health programs have been established in all Australian jurisdictions except the NT

[41] Kay M. et. al. Developing a framework for understanding doctors' health access: a qualitative study of Australian GPs. Australian Journal of Primary Health 2012;18:158-165.

and Tasmania. While all have the objective of offering a point of entry to the health care system for doctors needing advice and/or care, they vary significantly in their structure and the programs and services they offer.

A description of the five external doctors' health programs currently operating in Australia, together with descriptions of a number of health and wellbeing services offered to doctors by other professional organisations, is included at Attachment 3.

7. CONSULTATION OUTCOMES

The following themes emerged from the stakeholder consultation conducted as part of this project. It should be noted that the comments set out in this section reflect statements made and views expressed by stakeholders. Except where specifically stated, they are neither endorsed nor discounted by the authors of this report.

7.1 Demand issues

While most callers to doctors' health programs are medical professionals with concerns about their own health and wellbeing, a significant proportion of calls are received from family members, colleagues, educators and employers of medical professionals

Specific groups in medicine face higher barriers to accessing health care or are especially vulnerable to poor health and wellbeing and do not currently have good access to doctors' health programs. These include rural doctors, women in medicine, indigenous doctors and international medical graduates.

Medical students generally have poor knowledge of doctors' health programs and their access is consequently limited.

Older doctors with physical health problems represent a small but possibly increasing caseload.

The quality of public sector workforce management varies significantly and public health care organisations vary in their understanding of and concern for doctors' health and wellbeing.

Distressed young doctors are forming an increasing proportion of the caseload of some programs.

Investigations by the Board create great uncertainty and stress for medical professionals. The approach to investigations appears to vary between jurisdictions. Medical professionals who are under investigation require significant support and advocacy.

7.2 Impact of mandatory notification provisions of National Law

Many stakeholders suggested that the mandatory notification obligation included in the National Law creates a significant barrier to engagement by some medical professionals with health providers.

Some external doctors' health programs have experienced a decrease in activity over the past 2-3 years, which some stakeholders attribute to the mandatory notification provisions of the National Law, but this is not universal - activity levels of other programs have continued at historical levels.

Some programs are experiencing an increasing number of inquiries from doctors and employers about their responsibilities with respect to the mandatory notification provisions of the National Law.

7.3 Service provision

The 24 hour, 7 day a week telephone access to a senior, experienced medical practitioner offered by doctors' health programs is critical to service integrity and quality.

Some programs use a paging system or answering service, with calls answered and immediately transferred to an on-call medical practitioner. In other programs, the on-call doctor carries a mobile phone and answers calls directly. The use of an answering service screens participating doctors from inappropriate calls (e.g. members of the public seeking access to a GP) and appears to be acceptable to callers.

Some callers only require an initial one-off telephone consultation, but most are referred for a face-to-face consultation with a general or specialist clinician. Most programs provide the referral but not the subsequent consultation and generally advocate that medical professionals' health should be 'normalised' and medical professionals should be supported to access 'mainstream' health services rather than provided with dedicated 'doctor only' services. The exceptions are SA, which has developed a dedicated general practice clinic as an option that is used by some doctors, and Victoria, which offers both an initial face-to-face consultation for a relatively high proportion of callers and specialist case management, follow up and return to work services for a limited number of medical professionals for whom such services are deemed appropriate.

Most programs maintain a formal or informal 'list' of doctors with an interest and expertise in the care of medical professionals. In one jurisdiction, doctors are required to be credentialed to be included on the list.

All programs emphasised the importance of provision of clinical services by doctors who have a strong and transparent commitment to privacy and confidentiality and provide very high quality care.

All programs provide educational services to medical schools, employers and professional groups, but advised that their capacity to do so is limited by lack of funding.

A number of the programs conduct 'doctors-for-doctors' training, to equip doctors to provide quality services to their colleagues. The continuing professional development points generally available for such training support participation.

The NSW organisation provides website support for all other organisations delivering doctors' health programs nationally.

Some stakeholders reported that in the past external doctors' health programs had a closer relationship with, and at times received referrals from, their jurisdictional medical boards. This practice has ceased with the advent of the NRAS.

7.4 Resource issues

Stakeholders generally agreed that the costs of external doctors' health programs should be borne by the medical profession as a whole, and therefore supported continuing funding of programs by the Board[42]. Many stakeholders suggested, however, that where high quality 'mainstream' services are available medical professionals should be educated about and referred to them, and resources should be applied to providing dedicated services for the medical profession only if clear service gaps are identified.

All stakeholders identified a shortage of resources as significantly limiting their ability to provide important services.

Only two organisations engage doctors who provide face-to-face assessment, follow up and case management and return to work services (Victoria) and face-to-face assessment and treatment services (SA). In most jurisdictions, doctors who provide on-call services are not remunerated for those services.

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42 The NRAS is funded by practitioners' registration fees and there is no cross subsidisation between professions and no ongoing government funding nor subsidies.

Most stakeholders reported limited administrative resources and many reported insufficient resources to maintain basic activity statistics or evaluate their services or programs.

In a number of jurisdictions, State branches of the AMA provide considerable practical support. Some programs are also supported by pharmaceutical companies, medical indemnity providers and other donors and sponsors.

7.5 Leadership and governance

There is a very strong commitment to continuing State and Territory-based doctors' health programs that are led by recognised and respected clinicians and have strong knowledge of and linkages with local health care systems.

Where organisations delivering doctors' health programs have incorporated, there is a board of management or governance composed mainly or entirely of medical professionals.

Only two organisations (Victoria and SA) employ a medical director.

Most organisations have limited formal clinical governance arrangements in place. Meetings of participating doctors are convened in some circumstances to discuss difficult cases.

All stakeholders emphasised the importance of program leadership by doctors who are known and respected within their jurisdiction.

Nationally, there is a high degree of collaboration and there is universal agreement that the Network should be funded and supported.

The biennial national conference is viewed as an important opportunity for demonstrating sectoral leadership, networking and knowledge-sharing.

8. RECOMMENDED PRINCIPLES TO UNDERPIN BOARD SUPPORT

On the basis of our review of the literature and consultation and having regard to the objectives and the guiding principles set out in the National Law, we recommend the Board adopts the following principles as the basis for its support of external doctors' health programs.

1. To promote the objective of protecting the public, external doctor's health programs should encourage early identification and effective management of health issues affecting medical professionals. To do this, external doctors' health programs should:

    (a) be structurally and operationally independent of the Board and other regulatory bodies;

    (b) provide or facilitate non-discriminatory access to high quality health care services; and

    (c) actively raise awareness amongst medical professionals of the health issues that affect the profession, and available services.

2. To promote the objectives of accountability, transparency, efficiency, effectiveness and fairness, external doctors' health programs should:

    (a) operate within robust accountability and governance frameworks;

    (b) provide a clearly defined range of services to clearly defined standards;

    (c) encourage voluntary contributions by peers; and

    (c) be regularly evaluated for their effectiveness.

3. To support medical professionals to take personal and professional responsibility to maintain their own health and to seek appropriate assistance to manage poor health, external doctors' health programs should:

    (a) as far as possible ensure that doctors who provide health care to medical professionals are senior, have experience in treating medical professionals and do not have close professional or personal relationships with the medical professionals they treat;

    (b) value and protect confidentiality and privacy (subject to statutory reporting requirements);

    (c) ensure medical professionals are treated as patients, not colleagues; and

    (d) support medical practitioners who are ill to continue to practise their profession safely within the limits of their capabilities.

Recommendation 1

That the Board adopts the principles proposed in this report as the basis for its support of external doctors' health programs.

9. SERVICE OPTIONS

9.1 Core services

Typically, doctors' health programs in Australia and other relevant jurisdictions including the United Kingdom (**"UK"**), United States of America (**"USA"**) and Canada offer a range of services that can be classified under the following broad headings:

- Advice and referral
- Direct care (general practice, case management and related services)
- Education and awareness
- Advocacy and peer support
- Administration.

A limited or broad range of services may be offered under one or more of these headings.

We have identified services that are generally common to all external doctors' health programs in Australia and internationally, and for which we believe there is a strong rationale for Board funding on an equitable basis across jurisdictions.

We therefore recommend that the Board funds provision of the following services for access by medical professionals in all jurisdictions.

Advice and referral

- provision of information and advice (via the internet, through distribution of published material and in response to direct inquiry) about the services offered and the protocols that apply to their delivery;
- initial access (via telephone or in person) to an experienced doctor for the purpose of a high level assessment and advice on health care and wellbeing options;
- referral to an appropriate doctor for urgent or routine care - this may be a GP or a specialist including a specialist in mental health or drug and alcohol care;
- referral for psychological counselling; and
- development, maintenance and publication of a list of GPs and specialists (including mental health and drug and alcohol specialists) interested and with expertise (and in some cases 'credentialed') in the provision of services to medical professionals.

Education and awareness

- publications about doctors' health and health programs;
- internet sites and links to relevant third party sites;
- clinical tools to assist doctors to manage medical professionals as patients;
- tools to assist medical professionals to recognise and appropriately manage their own health care needs;
- promotion of programs and services;
- training for medical students, employers, professional groups and other stakeholders about doctors' health, the importance of health promotion, illness prevention and appropriate health care for medical professionals; and

- training for doctors on the management of medical professionals as patients.

Administration

- liaison with other doctors' health services;
- maintenance of stakeholder networks; and
- monitoring, evaluating and reporting on program performance.

Advocacy

- liaison with and provision of expert advice to policy makers, jurisdictional stakeholders and regulatory bodies on doctors' health issues.

Active strategies to improve service access by medical professionals located in rural areas and in jurisdictions which are not currently serviced or are under-serviced, and to target services to currently under-serviced groups of medical professionals will need to be implemented to achieve the Board's objective of equitable access.

Recommendation 2

That the Board funds the provision in all jurisdictions of a standard suite of core services for medical professionals, including advice and referral, education and awareness, administration and general advocacy.

9.2 Direct care

Some Australian external doctors' health programs also provide the following services:

- Initial face-to-face assessment followed by:
    - case management, rehabilitation and return to work services; and/or
    - referral to appropriate health care providers;
- General practice services.

Below, we discuss whether these services should be funded by the Board and/or provided by external doctors' health programs.

Case management, rehabilitation and return to work services

Victoria is currently the only Australian jurisdiction in which an external doctors' health program offers an initial face-to-face consultation with a senior doctor followed by referral for specialist services when needed and, where appropriate, direct provision of case management, rehabilitation and return to work services.

The aim of the VDHP Case Management, Aftercare and Monitoring Program (**"CAMP"**) is to restore the medical professional to optimal health. The nature of CAMP services is described at Attachment 4.

To receive CAMP services, medical professionals are required to enter into an agreement with VDHP to comply with a comprehensive range of therapeutic measures, which may include primary monitoring by a VDHP clinician, attendance at a peer support group, workplace monitoring and chemical monitoring.

The VDHP also:

- conducts a weekly support group – the Caduceus Group. This group is exclusively for medical professionals with substance use problems. It meets weekly at an inner city location and is facilitated by professional counsellors; and
- works with medical professionals to facilitate a return to work program. With permission, the VDHP liaises with the medical professional's employer and/or colleagues to help them develop a return to work plan. This may involve a graduated return to work, a 'back to work conference' in the workplace and/or the appointment of a workplace monitor.

The VDHP offers these services to medical professionals if deemed clinically appropriate, regardless of whether they have been, or are subsequently, brought to the attention of the Board through self-notification or under the voluntary or mandatory notification provisions of the National Law.

Neither the VDHP nor any other external doctors' health program provides therapeutic mental health or drug and alcohol services directly. Instead, clients of all programs are referred to private providers for these services. In Victoria, the providers of these services liaise with the VDHP's case managers and senior doctors in accordance with agreed protocols.

The VDHP is keen to receive funding for its case management and related services on the basis that:

- the services have been shown to be highly effective;
- the availability of these services under a health, rather than a regulatory, framework:
    - encourages earlier presentation for care by medical professionals, thereby reducing the likelihood of progression of illness to a point where the medical professional's career and/or patient safety are threatened;
    - leads to better health outcomes for medical professionals because intervention is likely to occur earlier and in a health rather than a regulatory context; and
    - improves public safety, because programs that offer these services implement early and reliable mechanisms to ensure unwell participants do not work in a manner that would expose the public to risk;
- case management services that are not dedicated to medical professionals are most unlikely to be acceptable to many medical professionals for the reasons described earlier in this report; and
- many medical professionals who are unable to work because of ill health do not have the financial means to self-fund case management services.

The question for this project is whether such services should be funded by the Board and/or provided by external doctors' health programs.

If the Board funds such services, the principle of equity will require them to be available to medical professionals across Australia, not just in Victoria.

Although the Board encourages those medical professionals who are subject to its regulatory oversight to seek assistance and support, which may include support from external doctors' health programs[43], it has emphasised its strong view that external doctors' health programs should not

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[43] Medical Board of Australia. Information on the management of impaired practitioners and students. Accessed on 2 January 2014 at http://www.medicalboard.gov.au/Notifications.aspx.

monitor impaired medical professionals on its behalf. Consultation with Board representatives confirmed that the Board adopts a regulatory rather than a health-oriented approach when dealing with impaired medical professionals and also highlighted a concern that case management and related services could be offered inappropriately to medical professionals without notification of those professionals to the Board in accordance with the National Law.

We have therefore considered three options in relation to the provision of case management and related services:

1. Subject to formal evaluation of the impact of case management and related services, the Board funds provision of case management and related services in all jurisdictions.
2. The Board does not fund case management and related services but external doctors' health programs have the option of providing such services utilising funds from other sources (e.g. insurance, Medicare, out-of-pocket payments by clients etc.).
3. The Board does not fund case management and related services and, because of the risk of inappropriate substitution of Board regulatory oversight of impaired doctors, does not support Board-funded external doctors' health programs accessing external sources of funding and providing such services.

As noted earlier in this report, health practitioners who work for doctors' health programs and/or provide therapeutic care to medical professionals referred by those programs are subject to a statutory obligation to notify the Board if they form a reasonable view that a medical professional who presents for care has engaged in notifiable conduct, and the Board has not otherwise been notified.

Noting the distinction between illness and impairment, as discussed earlier in this report, we believe that Board support for case management and related services is not inconsistent with the regulatory role of the Board, provided that the National Law's requirements for mandatory notification are reliably met. Specifically, such services are appropriately provided to medical professionals:

- who are ill but have not met the threshold for mandatory notification to the Board, and therefore may not be known to the Board; or
- who are or will be, because of mandatory notification obligations in the National Law, under the regulatory supervision of the Board but would also benefit from case management and related services.

Although operating in different and not necessarily comparable regulatory contexts, there are a number of examples in the USA, Canada and the UK of external doctors' health programs providing case management and related services that are formally supported by regulatory authorities.

We found evidence pointing to the success of case management and rehabilitation of impaired doctors by external doctors' health programs[44] [45]. We were unable, however, to locate any studies that evaluated whether jurisdictions in which case management and related services are available achieve overall better outcomes (of earlier presentation for treatment, improved treatment outcomes and improved public safety) than jurisdictions in which such services are not offered. We believe it

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44 Brewster J.M. et. al. Characteristics and outcomes of doctors in a substance dependence monitoring programme in Canada: prospective descriptive study. BMJ 2008; 337.

45 Wile; Frei; Jenkins. Drs & med stds case mgd by an Aust Drs Health Pgm. Aust Psych 2011 (19) 3: 202-204.

would be possible to design an appropriate study, but it would require access to sensitive data held by the Board and external doctors' health programs.

While only small numbers of medical professionals require case management services, they are usually required for a prolonged period of up to five years. On the basis of numbers of doctors receiving case management and related services in Victoria, where such services are well-established, we predict that nationally, approximately 180 medical professionals could benefit from such services at any time.

Following careful consideration, we have reached the following conclusions:

- some medical professionals who are affected by serious illness are likely to benefit from specialist case management, rehabilitation and return to work services;
- external doctors' health programs are appropriate organisations to provide such services;
- the impact of such services on system-level outcomes has not been established;
- if the provision of such services is funded by the Board, access to them should be available equitably to medical professionals across Australia;
- patient safety must remain the priority – external doctors' health programs that deliver case management and related services must comply strictly and transparently with the notifiable conduct provisions in the National Law;
- medical professionals who are under Board regulatory supervision may benefit from case management and related services, and referrals between the Board and external doctors' health programs would therefore be appropriate in some circumstances; and
- to maintain the confidence of the public and the Board, if external doctors' health programs funded by the Board provide case management and related services they should operate in accordance with explicit, transparent and accountable protocols addressing:
    - criteria and processes for acceptance of medical professionals into case management programs;
    - monitoring and supervision arrangements;
    - discharge arrangements; and
    - the circumstances under which relapses and other non-compliance must be reported to the Board.

We note that stakeholders consulted for this project other than those associated with the VDHP expressed some concern about the cost and complexity of providing such services. On this basis, we suggest that it would be reasonable for the Board to adopt option 1 above and continue to fund the VDHP to provide case management and related services while an independent evaluation is implemented to determine whether, in the Australian context, the availability of these services achieves the expected system-level outcomes of:

- earlier presentations;
- better therapeutic success rates; and
- overall improved public safety.

This will require a robust research design, systematic data collection and comparison between jurisdictions with and without dedicated case management and related services.

Later in this report, we describe the governance arrangements and communication protocols that we believe will be necessary to maintain public and Board confidence in such programs, if the Board elects to fund them.

Recommendation 3

That the Board:

- funds the continuing provision of case management and related services by the VDHP for a period of three years;
- commissions an independent evaluation to determine whether the availability of those services achieves the expected outcomes of earlier presentations, better therapeutic success rates and improved public safety; and
- when the outcomes of that evaluation are available, reconsiders the costs and benefits of funding equivalent services in all jurisdictions.

In light of our conclusion that it is appropriate for case management and related services to be funded by the Board, we also see no barrier in principle to those services being provided by external doctors' health programs utilising funding from alternative sources, if the Board elects not to fund them and subject to any system-level evaluation confirming no net detriment to public safety. We suggest, however, that it should be a condition of receipt of any Board funding that clearly defined and transparent governance and compliance arrangements are implemented for all services provided by external doctors' health programs, not only those that are funded by the Board. This will be necessary to maintain public confidence, noting that the public is unlikely to make a distinction between services that are funded by the Board and those that are not, if governance or compliance problems arise.

We believe there will be significant practical problems, however, in providing case management and related services in the absence of Board funding. We note that potential sources of funding for these services include user-pays, grants from organisations such as medical indemnity insurers and various forms of personal insurance held by medical professionals. During consultation for this project stakeholders advised that it will be extremely difficult if not impossible for external doctors' health programs to access the resources necessary to offer case management and related services either equitably or sustainably, in the absence of Board funding. We have been informed that many medical professionals that access services currently are either un- or under-insured and have limited or no capacity to work. The low case numbers, variable demand and specialist nature of the services mean that the fixed costs for service availability are relatively high. Opportunities for reimbursement for case management through Medicare are limited. Most external doctors' health programs have not commenced providing such services because of concerns about service sustainability without an adequate and reliable source of funding.

Recommendation 4

That the Board notes that while there is no barrier in principle to external doctors' health programs providing case management and related services funded from non-Board sources if the Board decides not to fund those services, the availability of funding is likely to be limited and the sustainability of services is therefore likely to be very uncertain under such circumstances.

Face-to-face assessment and referral

The infrastructure including consulting rooms and administrative support needed to provide case management and related services also supports the provision of initial face-to-face assessment of most Victorian clients by a senior clinician. This service is not offered in other States and Territories but according to VDHP stakeholders it often allows identification of needs that are not apparent during telephone-based consultations.

If the Board elects not to fund case management and related services, it would be inefficient for external doctors' health programs to establish the infrastructure necessary to provide other face-to-face services. In those circumstances, a solely telephone-based referral and follow up service is likely to be most appropriate in all jurisdictions.

Dedicated general practice services

We were impressed by the energy and enthusiasm with which the leadership group of Doctors' Health SA has established and operated a dedicated general practice for SA medical professionals.

The model of care is well-documented and appears to be robust, and the practice appears to be well-governed. Evaluation suggests that the practice is valued by the doctors who attend it.

Practice costs are, however, extremely high. The annual operating expenditure to 30 June 2013 (excluding depreciation) of Doctors' Health SA Limited was almost $340,000. In calendar year 2013 there were 143 new patients and 214 follow up patients. Sales of $32,837 were recognised in the annual accounts – we have assumed this represents Medicare billings assigned to the practice plus gap payments received from individual patients (the standard gap payment is $30.00 for an initial 30 minute consultation and $60.00 for a longer subsequent consultation[46]). The net annual cost to the program, therefore, of providing a dedicated general practice clinic for 4 sessions per week, together with the associated activities of the program including training doctors, establishing and maintaining a list of credentialed GPs, conducting a telephone crisis line and provision of general education about doctors' health was approximately $300,000. Assuming all services other than the general practice clinic could be provided for a cost of $180,000, based on the budget submitted by Doctors' Health SA, the net cost (for new and returning patients) of conducting the general practice clinic is estimated to have exceeded $330 per patient visit.

We think it is inevitable that a dedicated general practice with a small client base and a doctor-only model of care will incur very high costs, particularly when the service is not intended to provide ongoing care, as is the case in SA. Trends in general practice are clearly towards the development of large, multidisciplinary practices, partly driven by the significant requirements for infrastructure investment in rooms, communication resources, practice management and information technology and partly driven by the introduction of Medicare-billable items that support multidisciplinary care. The publication: *General Practice Activity in Australia 2009-10*, for example, reported only 15% of participating GPs practised in practices that employed less than 2 full time equivalent GPs. The proportion of GPs working in solo practice who participated in the BEACH study more than halved between 2000-01 and 2009-10, and the proportion in smaller practices of 2-4 GPs also decreased[47].

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46 http://www.doctorshealthsa.com.au/gp-clinic-appointments/.

47 Australian Institute of Health and Welfare. General practice activity in Australia 2000-01 to 2009-10: 10 year data tables. Accessed on 3 January 2014 at http://www.aihw.gov.au/publication-detail/?id=6442472440.

While we were unable to locate any publications that define optimal business models for stand-alone doctors' health services, in February 2009 the Victorian Department of Human Services published: *A guide to developing an optimal business model for general practice in community health* (the Guide). The Guide stated as follows:

> *"During consultation for this project, Inner East Community Health Service management indicated that 5 GP FTE is optimal as it provides an appropriate revenue base that can support overheads of approximately $300,000 – $350,000, which brings the practice close to a break-even financial position.*
>
> *However, determination of the 5 FTE figure was based on the assumption that increased throughput and numbers of GPs are the key drivers to practice viability. Viability can also be supported by:*
>
> - *maximising the role of other support staff (such as practice managers, practice nurses and administration staff);*
> - *improving MBS claiming and developing new models of care - particularly those that use practice nurses - which address the complex needs of community health patients.*
>
> *Adopting this approach may mean that the optimal number of GPs to support viability is less than 5 FTE."*

Even if the Doctors' Health SA business model is modified to reduce fixed costs associated with premises and equipment, as has been proposed, we do not think resources pooled from contributions of the profession across Australia should be applied to support the extremely high overhead costs of this or similar practices when reasonable and sustainable alternatives exist and are already accessed by many medical professionals. We believe resources should be prioritised towards educating medical professionals about the benefits of establishing a strong therapeutic relationship with an experienced GP, and developing and maintaining networks of such GPs, rather than operating a dedicated general practice for that purpose.

Recommendation 5

That because of very high establishment and operating costs the Board does not fund general practices dedicated to the care of medical professionals, but instead supports external doctors' health programs to provide education and network development activities that enable medical professionals to routinely access experienced GPs working in established general practices.

9.3 Peer support

Some doctors' health programs provide informal peer support to medical professionals facing regulatory or medico-legal action. This may include peer-based emotional support or accompanying (or identifying someone to accompany) a medical professional to a court session or to a Board hearing.

Many stakeholders consulted during this project highlighted the extreme stress medical professionals experience when they are subject to medico-legal or regulatory action and the absence of appropriate supports. While the Board makes efforts to explain processes and demonstrate respect for medical

professionals who are subject to its regulatory action, it does not offer a peer-based support service[48]. We were informed that a service provided previously by the Medical Board of Victoria was not well-used and that most medical professionals who are subject to regulatory proceedings already receive support through their medical indemnity insurers.

The intent of peer support services is not to provide legal or clinical advice, but to provide personal support at an extremely stressful time.

Internationally, the British Medical Association ("**BMA**") was commissioned by the General Medical Council ("**GMC**") to provide a Doctor Support Service as a two-year pilot, commencing May 2012[49]. The Doctor Support Service functions independently of the GMC and offers emotional help from fellow doctors for doctors who are subject to a complaint to the GMC. The objective is to ensure that doctors have access to support should they feel they need it, in particular doctors who are unrepresented or who have a health problem. Any doctor about whom a complaint has been made to the GMC can ask for support from the service. A dedicated telephone line is staffed during business hours. Support is available from when a complaint is made until the case is finalised. The service is free and available to all doctors, regardless of whether they are members of the BMA. Telephone support can be accessed and face-to-face support is also available, subject to availability of supporters, on the first day of a hearing and one further day if the hearing runs for more than one day. The supporter also arranges an orientation visit to the hearing centre early on the morning of the hearing if required. The supporter may be asked to accompany a doctor if they are required to attend a fitness to practice hearing. The service does not offer medical advice, or legal advice about cases.

There are potential limits on the Board's capacity to fund peer support and similar advocacy services. As noted above, the Board's power to provide financial or other support for external doctors' health programs is a statutory power conferred by the National Law[50]. For this purpose 'health program' is defined to mean[51]:

> *"a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence".*

It is not clear that provision of support or advocacy services in the context of regulatory action involving the Board or medico-legal proceedings would fall squarely within the definition of a 'health program', even where the action arises because of a medical professional's impairment.

If there are positive outcomes from the BMA/GMC project and provision of such services in the Australian context is considered further, it would be desirable to limit the range of circumstances in which peer support and advocacy are provided to situations where medical professionals have impairments or other health issues that may be exacerbated by their involvement in regulatory or

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48 According to the Board, "...interactions with the Board and AHPRA can seem formal and bureaucratic. While some of this cannot be avoided, staff will work with the practitioners and students to explain the various processes and requirements. Practitioners and students can expect their dealings with AHPRA and the Board will be professional, respectful and polite." See Medical Board of Australia. Information on the management of impaired practitioners and students. Accessed on 3 January 2014 at http://www.medicalboard.gov.au/Search.aspx?q=management%20of%20impaired%20practitioners.

49 http://bma.org.uk/practical-support-at-work/doctors-well-being/doctor-support-service

50 Section 35(1)(n), Health Practitioner Regulation National Law.

51 Section 5, Health Practitioner Regulation National Law.

medico-legal action or that may prevent or hinder their ability to effectively represent their interests in the context of that action.

Recommendation 6

That when the outcomes of the BMA/GMC pilot program are available, the Board further considers whether peer support should be included in the suite of funded services and if so, the appropriate scope of such services.

10. SYSTEM DESIGN OPTIONS

10.1 System configuration options

As noted above, independent organisations (incorporated or unincorporated) in five jurisdictions and an individual in a sixth jurisdiction currently operate external doctors' health programs, however:

- medical professionals in Tasmania and the NT do not have access to local programs
- the reliance of the ACT program on a sole practitioner raises questions about its sustainability; an
- the effectiveness of all programs in achieving equity across different sub-groups in medicine (e.g. students/doctors, urban/rural medical professionals, women, indigenous, international medical graduates) is unknown.

We were unable to identify any literature addressing the optimal configuration of doctors' health service systems, although we note that in a number of international settings doctors' health programs are state- or province-based.

Noting that the Board is a national body that is required to have regard to principles of efficiency, effectiveness and fairness in the performance of its functions, the question arises as to how it might support a doctor's health service system so that, as far as possible, services are:

- accessible to medical professionals anywhere in Australia
- provided efficiently
- provided at an appropriate level of quality; an
- provided by organisations that are subject to appropriate levels of accountability.

It is necessary to consider whether supporting the current network of multiple independent organisations and programs is the most effective way of meeting these objectives, or whether the service system should be restructured to achieve greater access, efficiency, quality and/or accountability.

We have considered two potential service system configuration options in detail:

1. Option 1 - An organisation that operates a single national program across all jurisdictions, with some functions and services centralised and others delivered on a 'hub and spoke' basis, as appropriate.
2. Option 2 - A multi-organisational service system:
    - 2.1. in which each organisation:
        - 2.1.1. provides services to medical professionals in defined geographic areas; and
        - 2.1.2. operates within a common national policy and procedure framework; and
    - 2.2. with centralisation of some functions and services where justified by efficiency, quality and/or accountability objectives.

There is strong support among stakeholders for the current multi-organisational service system. Leadership by doctors who are recognised and respected within local professional networks and who have good knowledge of and links with local health care providers is widely considered to be essential if programs are to succeed in their goal of facilitating and encouraging medical professionals to seek out their services. On the other hand, stakeholders also recognise that benefits could be gained through national leadership and co-ordination, and possibly also through service provision in some areas.

Our view is that the existing arrangement of multiple State- and Territory-based organisations misses opportunities for improved efficiency, effectiveness and fairness that would come with a national approach. Replacing the existing organisations with a single organisation, however, would lose the responsiveness to local conditions and stakeholder needs that is a clear benefit of the current arrangement.

If there were not established organisations with substantial engagement of medical leaders in six jurisdictions, we would recommend a single national provider with service delivery tailored to the specific needs of each jurisdiction. There was a strong preference by existing organisations and the medical professionals engaged in their leadership, however, for a continuing multi-organisational network, enabling management and governance to remain closely integrated with service delivery locally. The compliance costs and complexity of this arrangement are likely to be higher than those that would be incurred with a single national provider, but we have concluded that the best approach to maintain this critically-important engagement is to support the existing organisations and to formalise the structure and roles of the Australasian Doctors' Health Network ("**Network**") to enable national coordination and standardisation of service provision where possible. Higher compliance costs will be offset to some extent by the continuing volunteer input of a significant number of medical professionals in all jurisdictions and standardisation of systems where possible.

We therefore support maintenance of the current service system configuration with standardisation and centralisation of some aspects of governance and operations, including adoption of a common national quality and compliance framework, to enhance overall system performance. We believe that a system comprised of multiple independent organisations supports a desirable level of local engagement, underpinning access, quality and sustainability. For efficiency, quality and accountability, however, we believe that some key functions can be centralised and/or standardised.

Below, we discuss the potential configuration options and the rationale for our recommended approach in more detail.

Option 1 – a single national program

Under this model, a single organisation would provide services in all jurisdictions, including in currently un-serviced jurisdictions (the NT and Tasmania) and under-serviced jurisdictions.

While some activities could be undertaken and services delivered from a national base (e.g. 24 hour telephone advice and preparation of policies, educational material and other tools), a national provider would still need to deliver some services locally (e.g. education seminars and network development in each jurisdiction). Further, if the Board supports provision of case management services in each jurisdiction, local physical and service infrastructure would be required.

The number of telephone presentations to external doctors' health programs is relatively small at present and from a volume perspective alone telephone inquiries could be readily managed nationally by a single provider organisation. A number of other potential benefits could also be gained by appointing a single provider organisation to deliver services nationally, including more efficient use of infrastructure, a simpler interface with the Board and a consistent national approach to service delivery and accountability.

We do not support this approach, however, for the following reasons.

1. Firstly, we accept the proposition that doctors' health programs are highly specialised. Programs need to be managed and governed and services need to be provided by doctors

with specialist expertise, which has been developed over many years within existing programs.
Outside the current service system we have not identified any organisation(s) with the experience and resources needed to lead a national program.

Amongst those involved in the existing service system, there is a very strong preference for maintenance of local governance, management and service delivery.

We think it would be very challenging to identify an organisation with the necessary expertise and commitment to offer a reliable and sustainable national service.

2. Secondly, the proximity of governance and management to the medical professionals to whom services are offered will be a key success factor. Confidence in established programs, and therefore the willingness of medical professionals to participate in service provision and/or to use services, relies to a large extent on the personal reputations of local program leaders. We believe that this confidence would be difficult to reproduce under a national model in which organisational leaders would inevitably be more distant from, and may not be known at all to, local medical communities.
3. Finally, we believe that the opportunity to be engaged in program direction, management and governance as well as service delivery is a significant professional attraction for many volunteer doctors who provide much of the service. We believe the volunteerism that is essential to viability of the current service system would most likely be lost if the organisations that currently deliver programs are not supported to continue to do so.

Option 2 - A multi-organisational service system

To maintain volunteer commitment and retain and build on the significant expertise developed in a number of organisations over many years, we recommend that the Board directs its funding for external doctors' health programs to the five organisations already operating programs in NSW, Queensland, Victoria, SA and WA.

We consider that the medical professional populations in the NT, ACT and Tasmania (1.9%, 1.2% and 2.3% of the national medical practitioner workforce respectively) are too small to support independent local organisational structures, but that the Board's objective of equitable service provision can be achieved by allocating responsibility for ensuring service provision in these smaller jurisdictions to designated larger jurisdictions.

Accordingly, we recommend that the Board allocates formal responsibility to the organisations currently operating in NSW, SA and Victoria (**"Lead Jurisdictions"**) for governance and management of service provision in the ACT, NT and Tasmania (**"Supported Jurisdictions"**) respectively.

Similar partnering arrangements between these jurisdictions are already established for many clinical services and there are established links between the respective medical professional communities that will enable trust and confidence in service provision.

Services in the ACT are currently provided by a single doctor with no supporting organisational structure. Informal support is provided by the AMA. The intent of linking the ACT and NSW programs organisationally would be to ensure program sustainability. The longstanding commitment and experience of the doctor who has provided services for decades in the ACT is unquestioned and should continue to be valued and supported, but we do not believe it is viable or necessary, given the small size of the population of medical professionals in the ACT and the fact

that there is only one doctor currently involved in service delivery, to formally establish a stand-alone organisation.

Generally, the same model should apply in Tasmania and the NT, where there are no current services.

We therefore recommend that the Board supports a service system based predominantly on the existing doctors' health organisations, with the following overall service system configuration (**Table 2**).

Table 2: Recommended service system configuration

Organisation	Program responsibility
NSW Doctors' Health Advisory Service	ACT and NSW
Queensland Doctors' Health Advisory Service	Queensland
Doctors' Health South Australia	SA and NT
Victorian Doctors' Health Program	Vic and Tasmania
Doctors' Health Advisory Service Western Australia	WA

Program leaders in Lead Jurisdictions will need to work collaboratively with professional groups in Supported Jurisdictions to develop programs and services that will best meet the needs of local medical communities. It is likely that these programs and services will need to develop a local service identity, with management and governance support from their neighbouring jurisdiction. Ensuring provision of the suite of recommended core services including development and support of GP networks in Supported Jurisdictions would be a key responsibility for program leaders in Lead Jurisdictions. Appropriate accountability to the Board for equitable service delivery would need to be established.

Case management services, if provided in Lead Jurisdictions, should also be accessible on an equitable basis to medical professionals in their related Supported Jurisdictions. Not all services may be viable for local provision in smaller jurisdictions, but it would be the responsibility of each Lead Jurisdiction to ensure equitable access even if there is no local service delivery.

Although compliance and administrative costs are likely to be higher in a multi-organisation network than would be the case with a single national program, these will be offset to a significant extent by the opportunity to retain and build on the volunteer commitment evident in all existing programs and to standardise a number of policies, procedures, tools and services across programs, as discussed below.

10.2 A for-profit or not-for-profit service system

We recognise that the not-for-profit status of the existing organisations is a key strength of the service system and recommend its retention.

The difference between for-profit and not-for-profit organisations has traditionally been defined in terms of mission. The driving motivation of for-profit organisations is the generation of profit for the business owner(s), whereas not-for-profit organisations exist to fulfil their mission, usually

defined in terms of a social or community paradigm. In a structural sense, for-profit organisations are accountable to their shareholders, whereas not-for-profit organisations are accountable to their members, who generally have a strong commitment to the organisation's mission.

Not-for-profit organisations often are characterised by much higher levels of volunteering that for-profit organisations. Volunteering has been fundamental to the culture of external doctors' health programs and is a key vehicle for medical professionals who wish to support their colleagues. It also engenders trust in external doctors' health programs amongst the medical community, because medical professionals recognise the compassion and commitment to a healthy medical workforce that drives participants' involvement.

While there is no fundamental barrier to operating Board-funded external doctors' health programs on a for-profit basis, we recommend continuing not-for-profit operations to avoid losing a number of features of the current arrangement, including:

- the voluntary leadership contribution of experienced and respected medical professionals and involvement of peer professional volunteers in service provision in existing programs
- the trust and goodwill that exists within the medical professional community, much of which relates to the recognition that the program leaders and service providers are driven by a strong sense of mission; and
- the opportunity to achieve tax concessions.

We believe that Board funding should support, rather than replace, the volunteer contributions and significant specialist expertise that is evident in all existing programs, which would most likely be lost if a for-profit model were adopted.

There would be no barrier to not-for-profit external doctors' health programs purchasing some service elements from for-profit providers or referring clients to for-profit providers, as currently occurs.

Recommendation 7

That the Board funds the delivery of external doctors' health programs through a national service system based on the existing doctors' health organisations in NSW, Queensland, SA, Victoria and WA, with:

- NSW invited to assume organisational responsibility for services in the ACT
- SA invited to assume organisational responsibility for services in the NT;
- Victoria invited to assume organisational responsibility for services in Tasmania; an
- all organisations maintaining their not-for-profit status.

10.3 National leadership and co-ordination

The Network is an unincorporated and unfunded body that presently provides national leadership for external doctors' health programs in Australia and New Zealand, facilitating information-sharing between member organisations, advocating for doctors' health and wellbeing and, with the support of sponsors, conducting a biennial doctors' health conference.

Stakeholders described the Network as a critical element of an integrated and sustainable national doctors' health service system and strongly advocated for it to be formally established and funded.

The concept proposed to us is similar to the arrangements for co-ordination of state / provincial doctor's health programs in the USA and Canada. Broadly, the USA Federation of State Physician Health Programs (**"FSPHP"**) and the Canadian Physician Health Network (**"CPHN"**) have been established to:

- advocate for state / provincial doctors' health programs
- promote early identification and treatment of illness among doctors
- promote consistency in clinical and service standards;
- conduct and facilitate national and regional conferences; an
- provide informational resources.

The aims and activities of the FSPHP and CPHN are outlined in more detail in Attachment 5.

In the context of our recommended multi-organisational network, it is appropriate for the Board to fund a national leadership and co-ordination body that assumes this type of role. Modest funds would be required to establish such a body and support its operations, and we consider that these should be provided directly by the Board. For practicality and efficiency, the Network should be collocated with and administered by one of the existing external doctors' health programs. The Board could conduct an expression of interest process to determine which external doctors' health program is best placed to host and support the Network.

10.4 Standardisation and shared service delivery

Standardising some elements of organisational governance, in particular in the following areas, is desirable because it is likely to enhance equity of access, service efficiency, quality and accountability:

- clinical policies and procedures;
- data collection and reporting; and
- evaluation.

While under the recommended model each service delivery organisation will retain local governance and management responsibilities, appointment of a single organisation that is arms-length from the Board to coordinate development and implementation of a standard governance framework and to collect and report standardised activity and quality data to the Board will support good governance.

There is also the opportunity to improve access, efficiency and quality through direct delivery of some services on a national level, including:

- operating a single national telephone answering service (with calls answered on behalf of the jurisdiction of origin and transferred directly to the doctor on call for the relevant jurisdiction);
- hosting websites for all jurisdictional programs from a single location; an
- developing practice tools and educational resources, which could be tailored at a jurisdictional level to meet local needs.

We have considered two options for these roles:

1. Appointment of the Network (subject to its incorporation as recommended later in this report).

2. Appointment of one or more of the organisations that provides a jurisdictional doctors' health program to support providers in all jurisdictions on a 'lead agency' basis.

We believe selection of a 'lead agency' would unnecessarily complicate the relationship between the various doctors' health programs and the Board, and that collaboration between the programs might be compromised if one of the jurisdictional organisations providing services is appointed to this national support role. To maintain an appropriate level of separation from the Board and to ensure accountability of all participating organisations, our preferred option is to expand the role of the Network for the purposes set out above.

10.5 Stakeholder engagement

While external doctors' health programs in Australia are providing apparently effective services to many medical professionals, some of whom have reached a crisis point in their health and/or careers, the majority of medical professionals do not access these specialist programs. Awareness amongst students, in particular, appears to be low.

We consider that there needs to be a renewed focus on strategic partnerships nationally, to enhance awareness of external doctors' health programs. We consider that the Network should be resourced to collaborate with a range of organisations including AMSA, professional colleges and other professional groups such as the Australian International Medical Graduates Support, Advice and Advocacy Network and the Australian Indigenous Doctors' Association. The aim of the collaboration should be to develop specific strategies aimed at promoting good lifetime health practices and improving knowledge of available health services amongst the members of those organisations, particularly those who live and work in rural and remote areas and/or are currently under-serviced.

In summary, we recommend that the Network is funded and authorised to assume the following roles and responsibilities:

- coordinating the national network of doctors' health services and supporting information exchange between network participants;
- liaising with relevant national and international stakeholders;
- advocating for doctors' health and wellbeing;
- providing strategic advice and representation to the Board, government and other decision-makers;
- building capacity including hosting the biennial conference;
- developing standard national policies, procedures and tools (including educational resources) for implementation across the entire service system;
- hosting websites for all jurisdictional programs;
- providing a single national telephone answering service, with calls answered on behalf of the jurisdiction of origin and transferred directly to the doctor on call in the relevant jurisdiction;
- standardising data collection and centralising data analysis and reporting;
- coordinating research and evaluation nationally; and
- developing strategic partnerships with relevant medical professional organisations, with the objective of promoting good lifetime health practices and knowledge of available health

services amongst the members of those organisation, particularly those who live and work in rural and remote areas.

Recommendation 8

That the Board funds the Network to assume the ongoing leadership, advocacy, capacity-building and support roles defined in this report.

11. ORGANISATIONAL STRUCTURAL OPTIONS

11.1 Introduction

In developing recommendations on the organisational structure(s) that will best support delivery of external doctors' health programs in Australia, we have considered the following issues:

- Whether incorporation of the organisation(s) delivering services is necessary, and if so, in what form.
- The appropriate organisational membership structure(s).
- Board size and composition.
- Remuneration arrangements for directors.

All of these issues will have a direct impact on the robustness of governance, in particular the level of accountability to the Board and the public, of external doctors' health programs. It will be particularly important to establish appropriate organisational structures if, as recommended in this report, doctors' health programs offer case management and related services.

11.2 Incorporation

Existing external doctors' health programs in Australia have the following structures (see Attachment 3):

- A sole practitioner supported informally by the AMA (ACT).
- An informal group of practitioners supported informally by the AMA (WA)[52].
- Incorporated association (NSW and Queensland) supported informally by the AMA.
- Company limited by guarantee (SA and Vic)

The Network is presently unincorporated.

In our view all entities involved in delivery of external doctors health programs, and the Network, should be incorporated, with the following benefits:

- Creation of separate legal entities which can enter into contracts, own property and equipment, and sue and be sued.
- Protection of organisational participants (members and directors) from individual liability.
- Perpetual succession, supporting service sustainability despite changes in staff, organisational membership or membership of the governing body.
- Promotion of transparent and robust governance through:
    - the establishment of a properly-constituted governing body;
    - opportunities for formal stakeholder engagement in governance;
    - specification in a formal constitution of organisational mission, responsibilities and accountabilities;
    - the imposition of legal duties on directors.

[52] We have not analysed this structure in detail but note that it appears to be an unincorporated association.

- The ability for directors and officers to be appropriately insured.

Incorporation is a precondition for eligibility for tax concessions.

While it is possible for the Board to fund unincorporated entities, we consider that incorporation of all involved organisations will support higher levels of public and Board confidence and will be essential if services that carry higher governance and/or compliance risk, including case management and related services, are offered.

It was suggested to us that in jurisdictions in which existing entities are unincorporated the Board could enter into a funding and service agreement with the jurisdictional branch of the AMA, which would act as a fundholder for an unincorporated association. Under this arrangement the AMA branch would be responsible for contractual accountability but would delegate operational authority and responsibility to the existing service providers.

Jurisdictional AMA branches have been loyal and highly supportive partners of a number of doctors' health programs, and these partnerships should be encouraged and hopefully will continue. However, we do not recommend that the AMA has any formal role in governance of external doctors' health programs because of the potential for conflict to arise (or be perceived) between the responsibility of the AMA to protect the interests of its members and the necessity that any external doctors' health program that is supported by the Board transparently demonstrates full compliance with the National Law (particularly in respect of mandatory notification).

In the context of the proposed program, options for incorporation include:

- incorporated association; and
- company limited by guarantee ('**CLG**') .

While, there is no barrier to the incorporated associations that already exist in NSW and Queensland entering into funding and service agreements with the Board, we consider there would be significant advantages if all organisations incorporated as CLGs. The advantages of a CLG include:

- The legislation under which incorporated associations are established is not uniform across jurisdictions, and hence incorporated associations in different jurisdictions would be established in different ways, regulated by different bodies and subject to different rules. CLGs, on the other hand, have a common legislative underpinning and are regulated nationally.
- Because they are incorporated under the Commonwealth Corporations Act, CLGs can carry out their activities anywhere in Australia. While options are available for incorporated associations to operate in multiple states, these can involve increased cost and administrative burden. If an organisation operates across State/Territory borders, there is a strong preference for a CLG structure.
- Incorporated associations were originally designed to be low cost to register and simpler to run than CLGs, but fees payable by incorporated associations in some jurisdictions have risen to a level that makes the costs associated with administering that structure closer to costs associated with running a CLG.
- For groups that are (or hope to be) registered as charities, the transition of regulation of CLGs that are registered charities from ASIC to the Australian Charities and Not-for-profits Commission (ACNC) (which commenced in 2012) also means that the regulatory approach and costs for the two structures is now closer.

- An incorporated association can be compelled by the relevant regulator to transfer its registration to that of a CLG under the Corporations Act, if the regulator considers that the incorporated association should more properly be regulated as a company (e.g. in light of the scale or nature of its activities, the value or nature of its property or the extent or nature of its dealings with the public).

We understand that the committee of management of the Doctors' Health Advisory Service Queensland has identified the need to review its organisational structure and constitution. When that occurs, it would be appropriate to consider changing the structure to a CLG. The NSW program is operated by an incorporated association. If that organisation is to assume responsibility for service provision in the ACT, as recommended in this report, it would be appropriate to move to a CLG structure. The organisations that operate the SA and Victorian programs are already established as companies limited by guarantee but may need to review their constitutions in line with the recommendations of this report. If our recommendations are accepted, the unincorporated association operating the WA program, and the Network, will both need to incorporate and should do so as CLGs.

Recommendation 9

That as a condition of funding, the Board requires the Network and all organisations that deliver Board-funded external doctors' health programs to incorporate, with a preference for a company limited by guarantee structure.

11.3 Company membership

In any corporation registered under the Corporations Act, the members of the corporation are its primary stakeholders.

Typically, the constitution of a CLG will provide that the members of the corporation are those individuals identified as members at the time the corporation is incorporated and any other persons who are admitted as members in accordance with the terms of the constitution thereafter.

Members will generally not have day-to-day decision-making powers or control over the corporation, or access to the corporate information on a regular basis. Nonetheless, it is for their benefit that the corporation's activities are primarily conducted. Further, members, as the primary stakeholders, can be given a significant say in how each external doctors' health program is governed, including through the power to election and dismiss directors and to approve any constitutional changes.

Current memberships of those organisations operating external doctors' health programs that are incorporated include (Table 3):

- individual doctors with an interest in doctors' health (NSW and Queensland);
- jurisdictional AMA branches (Queensland, SA and Vic);
- representatives of specialist colleges, medical benevolent associations and other professional groups (Queensland);
- Rural Doctors' Workforce Agency (SA);
- AHPRA (Vic).

The members of the Network are the organisations operating external doctors' health programs in all Australian jurisdictions and New Zealand.

We suggest that organisational membership structures should be simple, to avoid undue administrative burden for external doctors' health programs. We do not recommend multiple classes of membership[53].

The threshold consideration is whether individuals, legal persons other than individuals, or a combination of both should be organisational members.

We have not identified any particular barrier to both individuals and corporations or other legal persons becoming organisational members, and note that this arrangement operates without problems already in at least one jurisdiction. Permitting both individuals and legal entities to become members would create the opportunity for the widest inclusion and participation in governance.

We do not support, however, the inclusion of AHPRA as a member of any organisation delivering a Board-funded external doctors' health program. In our view, this arrangement, which currently exists in Victoria, fails to establish the requisite level of independence between the organisation and the Board, which will be critical for public confidence. While we do not believe AHPRA membership of the organisation has jeopardised the effective functioning of the VDHP, we consider there is a significant risk of that perception arising.

We recommend that membership of the Network be comprised of the various incorporated jurisdictional doctors' health programs, and is also opened to other interested organisations (including, for example, the AMA, AMSA, the professional colleges and other professional groups).

Recommendation 10

That membership of organisations that provide external doctors' health programs is open to individuals and relevant professional organisations, but that AHPRA is not a member of any organisation.

Recommendation 11

That membership of the Network is open to the incorporated jurisdictional doctors' health programs and other interested organisations (including, for example, the AMA, AMSA, the professional colleges and other professional groups).

53 The Corporations Act permits members of a corporation to be granted differing rights. This is typically achieved by allocating stakeholders different "classes" of membership. As a consequence, the corporation's membership is divided into a number of classes, with each class of members having distinct right as compared with other classes. A common example would be the creation of two classes of membership, namely, "voting members" and "non-voting members". The rights between these two classes might be identical but for the fact that non-voting members are not entitled to vote at general meetings of the corporation.

11.4 Board size and composition

A company limited by guarantee must have at least three directors but it is generally accepted that most Boards require a greater number of directors to function effectively and efficiently. If a board becomes too large, however, it may have difficulty operating efficiently and achieving the company's vision. A maximum board of between seven and nine directors is often proposed as ideal.

Boards/committees of managements of the organisations currently delivering external doctors' health programs are mainly but not exclusively composed of doctors.

In recent years, there has been a significant trend towards establishing boards on a skill-basis rather than on a representational or sectoral basis. A skill-based board is established primarily with a view to achieving the optimal balance of skills and experience at board level (as opposed to focussing on the representation of particular interests or stakeholders). This model is most closely aligned with current Australian directors' duties as well as the generally accepted principles of good corporate governance, as it seeks to optimize the composition and operations of the board so as to most effectively promote the interests and objects of the corporation. The preference for a skill-based board will usually be expressed with reference to a desired or mandated range of skills and experience to be included at board level.

The range of skills that we believe should be considered for inclusion in the skills-based boards of organisations delivering external doctors' health programs includes:

- medical professional, covering:
    - a range of career stages and workplace settings, from medical student through to independent doctor;
    - specialist skills in the management of impaired medical professionals; and
    - consumer (i.e. experience as a client of a doctors' health program);
- other health care professional (e.g. psychology);
- legal;
- clinical governance;
- financial;
- community advocacy;
- senior organisational management/governance.

We suggest that boards of external doctors' health programs and the Network should generally consist of a majority of experienced medical professionals with a meaningful complement of non-medical professionals. All boards should include at least one community advocate who is not a health care professional.

A skill-based Board will often involve a specified number of board seats being filled by appointment rather than election. Most commonly, it will be left to the board to appoint directors to those seats, taking into account the current range of skills and experience represented at board level and any critical gaps from the board's perspective. While in rare cases that power might be granted to an 'outsider' (for example, a government department or agency or other funding partner), in such circumstances there is a risk of the director being perceived as a nominee director, and for that reason we do not recommend that model.

11.5 Board remuneration

While it is not uncommon for directors of not-for-profit organisations to receive a stipend or salary, in the context of the strong spirit of volunteerism that has traditionally characterised the delivery of external doctors' health programs, we recommend that directors are not remunerated. We do consider, however, that directors' reasonable expenses, including relevant continuing professional development expenses, should be supported. If a multi-organisational network is to be viable, governance costs will need to be maintained at a reasonable level.

11.6 Protection for directors and officers

In light of the strict duties and ever-increasing exposure to personal liability to which directors and other company officers are subject under Australian law, it will be important to establish comprehensive director and officer protection regime (over and above appropriate risk management and governance practices). Typical approaches include:

- Including appropriate provisions in the entity's Constitution.
- Entering into a 'Deed of Indemnity, Insurance and Access' with the directors and, potentially other officers of the company to offer them additional protection.
- Entrancing and maintaining appropriate directors' and officers' insurance to protect those individuals against liability while they hold office and for an agreed period thereafter.

It should be noted that these protection arrangements are regulated under the Corporations Act and other statutes and raise a number of complex legal issues, including the nature of the benefits to be provided and which organ of decision making should authorise a company's entry into such an arrangement (i.e. the board or the members in general meeting). These matters will need to be the subject of specific legal advice as the model is developed.

Recommendation 12

That the Board requires organisations that deliver Board-funded doctors' health programs, and the Network, to establish:

- skills-based, volunteer boards of governance of between five and nine directors, including a meaningful quota of directors on each board who are not health professionals and at least one director on each Board who has expertise in community advocacy; and
- appropriate mechanisms to protect directors and officers from liability.

Recommendation 13

That directors of external doctors' health programs and the Network are not remunerated, but that their reasonable expenses, including professional development expenses, are supported.

12. FUNDING OPTIONS

12.1 Distribution of funding

In this section, we provide advice on:

1. Current estimated activity statistics and costs.
2. Option A - Proposed estimated statistics and resulting budget for a standard referral and follow up process for all States and Territories with case management continued in Victoria only for evaluation purposes, and centralisation of some functions.
3. Option B - Proposed estimated statistics and resulting budget for a standard referral and follow up process for all States and Territories, with case management not funded in any jurisdiction, and centralisation of some functions.
4. Option C - Profile to match a targeted budget if all States and Territories had access to case management and related services.

The following tables are provided

1. Current Estimated Statistics
2. Current Estimated Cost Structure
3. Modelled Annual Statistics – Options A and B
4. Modelled Annual Costs Structure – Options A and B
5. Unit costs – Options A and B
6. Modelled Annual Statistics – Option C
7. Modelled Annual Costs Structure – Option C
8. Unit Costs – Option C
9. Setup Costs – Options A, B and C.

The serviced population remains constant. The models 'round up' the number of doctors and medical students (see Tables 10, 12 and 15 for details by State).

Table 3: Current and potential serviced populations

	Current	Option A	Option B	Option C
Doctors	73,942	75,500	75,500	75,500
Medical students	15,397	16,200	16,200	16,200
Medical Schools	19	19	19	19

The level of activity is predicted to increase in Options A and B as more jurisdictions take on a formal approach with dedicated resources. Recorded activity levels are expected to more than double. Option C has more case management as the Victorian model would be applied in all jurisdictions (see Tables 10, 12 and 15 for details by State).

Table 4: Current and potential serviced client numbers

	Current	Option A	Option B	Option C
Contacts	800	1,640	1,640	1,640
Follow up	1,080	2,050	2,050	2,050
Case Management	**45**	**48**	**-**	**180**

The number of persons involved would increase in Options A and B and again in Option C. There would need to be more volunteers and more contracted human resources to run more formal programs, with the exception of SA where volunteer numbers are currently very high. Option B involves less people than Option A as the case management staff decrease. Because Option C is reduced to suit a budget the increase in psychologist case managers and clinical staff is off-set by a decrease in admin staff and medical directors (see Tables 10, 12 and 15 for details by State).

Table 5: Persons involved in service provision

	Current	Option A	Option B	Option C
Volunteers	111	65	65	65
Board members	39	42	42	42
Admin	4	7	6	6
Psych case mgrs	2	2	-	7
Clinical staff	2	1	-	5
Medical director	2	6	5	5
Total persons	**160**	**123**	**118**	**130**

The real effect of the budget changes is best described by the changes in hours worked. The budget trade-off is less administrative and medical director time and more case management time. Because case management time is available there would be less need for admin staff and medical directors to be available. While Option C in more expensive, it is not a direct add-on of expenses but includes some substitution of expenses (see Tables 9, 12 and 15 for details by State).

Table 6: Effective hours worked

	Current	Option A	Option B	Option C
Volunteers	1,140	3,280	3,280	3,280
Board members	936	336	336	336
Admin	2,900	4,264	3,848	3,536
Projects		416	416	416
Psych case mgrs	2,560	2,330	-	7,072
Clinical staff	640	874	-	1,643
Medical director	600	3,016	2,808	1,789
Hours worked	**8,776**	**14,515**	**10,688**	**18,072**

The total hours including volunteers would increase from around 8,800 to 14,500 nationally in Option A and to 18,100 in Option C. Option B would see a marginal net increase to 10,700 hours annually. In the first instance as a formal service is established in all States and Territories the administration and medical director hours are the most significant increases with some project hours for education materials and evaluation. For Option C the increase is related to case management.

The current cost of services is largely understated because of the provision of services in kind with support from state medical associations and a largely informal approach that is not documented in states other than Victoria and SA. The current cost structure in Victoria is a combination of referrals and case management and the provision of some clinical services. The current cost in SA is inflated by the provision of clinical services and other project costs. The financial statements in SA show current costs in excess of $300K per annum while the proposed budget is around $190K per annum, which is marginally higher with the standardised model cost in Option A.

The current cost of services is estimated at less than $1.0 million. This figure is distorted by a combination of case management and referral costs in Victoria and start-up, clinical and referral costs in SA. Against this the costs for NSW, Queensland and the ACT are understated by the fact that services are supported and the costs are not fully disclosed and that TAS and NT do not have recognised programs (see Tables 11, 13 and 16 for details by State).

Table 7: Cost structure

	Current	Option A	Option B	Option C
	$000	**$000**	**$000**	**$000**
Human resources	784.6	1,154.2	798.4	1,351.6
Purchased services	205.3	583.4	508.0	583.4
Total costs	**989.9**	**1,737.7**	**1,306.3**	**1,935.1**

Providing a formal service in every state with a case management service in Victoria and combined services in Victoria/Tasmania, NSW/ACT and SA/NT will require a budget of $1.7 million (Table 7). Included in the $1.7 million is $400K of case management costs for Victoria and $125K of costs for the Network including projects and call centre costs. It would be logical to align the Network with one of the established states.

Human resources (HR) costs are based on using an hourly rate for all staff utilised, inclusive of insurance, leave and on-costs and are paid for hours worked. Using this approach staff can be shared with other bodies and/or contracted through other institutions that have established employment procedures to take care of fringe benefits and other taxation requirements. It also allows each service to contract directly with persons who have registered Australian Business Numbers and contract their services to other parties. The nature of the service being provided is that persons will have experience in the medical field and will also be working in other fields. The doctors' health program is about volunteers and experienced persons working in health providing access to a range of persons depending on the skill set required at the time. HR practices need to be aware of this.

The hourly rates used in the budget model are as follows:

Table 8: Hourly rates

	Hourly Rate
Admin	$45
Projects	$50
Psych Case Mgrs	$80
Clinical Staff	$125
Medical Director	$200

The purchased service costs are based on the following assumptions:

- Office rental is based on a co-location of offices. The cost is based on $12K per annum for every 1,600 hours of effective work. This will work well as a cost share for collocated services. It is generous as it is effectively $120K per annum for 10 full time effective staff.
- Office expenses are set at 50% of rental costs.
- Legal, accounting and insurance costs are set at 5% of HR costs.
- IT and equipment costs are set at 7.5% of HR costs
- Education costs are based on 4 visits to each medical school per annum at a cost of $2,500 per visit. This includes time, travel and materials.
- The call centre is an annual fee to have access to call centre facilities in times when volunteers are not available. This is based on the SA budget.
- Advertising is based on $1 per medical professional in each state per annum.
- Telephone and computers are based on annual costs per annum for each person's working hours.
- Travel is a fixed amount.
- An amount of $400 per volunteer per annum to cover costs or provide CPD.
- An amount of $100 per board member per meeting to cover costs.

It should also be noted that only costs have been included in the budget. There will be revenue opportunities available in each State and Territory. Excluding these revenue opportunities recognises the fact that charging for services may discourage the use of services and that the Medicare billing system will only partially off-set costs and may create confidentiality concerns. Nevertheless the following opportunities exist to stretch the budget further to provide more worked hours or more education services:

- Co-payments for services offered.
- Billing Medicare for case management plans.
- Donations.
- Interest on invested funds.

In order to achieve a balanced budget some costs have been altered in Option C. Education, telephone and computer costs have been reduced along with some HR admin and medical director costs when case management HR costs have been added.

The unit cost of the service utilise the service. This should increase to around 2% if services are formalised and promoted in makes for interesting comparisons and reasons why the efficacy of the service should be evaluated.

It is estimated that currently less than 1% of medical professionals utilise services in all States and Territories. The cost per contact is around $1,200 currently and will remain around $1,200 in option C. The cost per contact drops in Option A because only one State is providing a case management service. In Option B where there is no case management the cost per contact drops to $800.

Table 9: Contacts and costs per medical professional

	Current	Option A	Option B	Option C
Contacts per medical professional population	0.9%	1.8%	1.8%	1.8%
Cost per contact	$1,237.38	$1,059.56	$796.53	$1,172.21
Cost per medical professional	$11.08	$18.95	$14.25	$20.96

The cost for all medical professionals (see Tables 14 and 17) is currently $11 per person. This will rise to $19 if better access is provided nationally and around $21 per person is access is provided to all along with case management to around 180 people annually. The cost without case management will be around $14 per medical professional including students.

For a cost of around $1.7 to $1.9 million per annum for external doctors' health programs it will be important to measure the efficacy in terms of economic as well as social outcome. There are several measures of efficacy that could be measured on an economic basis, for example:

- Does case management return health professionals to partial or full function more effectively than occurs through reliance on external services or regulatory approaches alone? This could be measured by levels of practice income generated before, during and after services are provided.
- Does the program diminish costs for both the individual and professional bodies? What are regulatory and legal costs with and without the external doctors' health program and case management services?
- What is the cost of reputation management to the sector in the absence of well utilised services?
- Are reputation management, public relations, regulatory burden and legal costs in Victoria and SA more favourable than in other states because they have more formal programs?

Set up costs for the national system have largely been incurred for VIC and SA. New processes and contracts will need to be established for NSW, Queensland and the ACT. A one-off cost for equipment would be incurred in NSW, Queensland and the ACT and additional costs would be incurred in SA if Option C was established. These costs are estimated in Table 18.

Recommendation 14

That the Board:

- funds external doctors' health programs for the first three years in accordance with the distribution presented in **Table 13** of this report to a total of $1.7 million in year one with an appropriate escalation for inflation in subsequent years; and
- notes the higher cost of providing case management and related services to all jurisdictions in the future.

Table 10: Current estimated statistics

Annual statistics	**VIC**	**TAS**	**NSW**	**ACT**	**SA**	**NT**	**WA**	**QLD**	**AUST**
Clinicians	18,106	1,709	23,819	1,374	5,963	895	7,237	14,839	73,942
Medical students	3,770	356	4,960	286	1,428		1,507	3,090	15,397
Medical Schools	3	1	6	1	2	-	2	4	19
Clients									
Contacts	300		120	30	240		40	70	800
Follow up	540				540				1,080
Case Management	45								45
Number of persons involved	**VIC**	**TAS**	**NSW**	**ACT**	**SA**	**NT**	**WA**	**QLD**	**AUST**
Volunteers	2	-	20	1	44	-	4	40	111
Board Members	9	-	13	-	7	-	-	10	39
Admin	1	-	1	-	1	-	-	1	4
Psych Case Mgrs	2	-	-	-	-	-	-	-	2
Clinical Staff	1	-	-	-	1	-	-	-	2
Medical Director	1	-	-	-	1	-	-	-	2
Total Persons	**16**	**-**	**34**	**1**	**54**	**-**	**4**	**51**	**160**

Effective hours worked per annum	**VIC**	**TAS**	**NSW**	**ACT**	**SA**	**NT**	**WA**	**QLD**	**AUST**
Volunteers	40		240	40	600		80	140	1,140
Board Members	216	-	312	-	168	-	-	240	936
Admin	1,600		250		800		-	250	2,900
Psych Case Mgrs	2,560								2,560
Clinical Staff	640				-				640
Medical Director	400				200				600
Total Hours	**5,456**	**-**	**802**	**40**	**1,768**	**-**	**80**	**630**	**8,776**

Table 11: Current estimated costs structure for doctors' health programs 2012-13

Annual expenditure	VIC $000	TAS $000	NSW $000	ACT $000	SA $000	NT $000	WA $000	QLD $000	AUST $000
HR costs									
Volunteers	0.2	-	2.0	-	4.2	-	0.4	4.0	10.8
Board Members	0.9	-	1.3	-	16.0	-	-	1.0	19.2
Admin	72.0	-	11.3	-	37.5	-	-	11.3	132.0
Projects	-	-	-	-	40.0	-	-	-	40.0
Psych Case Mgrs	243.2	-	-	-	-	-	-	-	243.2
Clinical Staff	118.4	-	-	-	96.0	-	-	-	214.4
Medical Director	90.0	-	-	-	35.0	-	-	-	125.0
Total HR	**524.7**	**-**	**14.6**	**-**	**228.7**	**-**	**0.4**	**16.3**	**784.6**
Purchased services									
Office Rental	20.0	-	1.0	2.5	20.0	-	-	2.0	45.5
Office Exp	2.0	-	0.1	0.2	22.3	-	-	0.1	24.7
Legal Acct' Ins	5.0	-	2.0	0.5	6.2	-	-	0.5	14.2
IT and Equipment	0.5	-	0.1	0.2	32.6	-	-	0.1	33.5
Education	-	-	-	-	25.0	-	-	-	25.0
Call Centre	-	-	-	-	5.8	-	-	-	5.8
Phone	1.5	-	0.1	0.3	1.7	-	-	0.1	3.7
Computers	1.5	-	0.1	0.3	-	-	-	0.1	2.0
Travel	5.0	-	3.5	-	10.0	-	-	3.5	22.0
Advertising	5.0	-	3.0	-	19.0	-	-	2.0	29.0
Total services	**40.5**	**-**	**9.9**	**3.9**	**142.6**	**-**	**-**	**8.4**	**205.3**
Total expenses	**565.2**	**-**	**24.5**	**3.9**	**371.3**	**-**	**0.4**	**24.7**	**989.9**

Table 12: Model annual statistics – options A and B

Annual statistics model	National Direct'	VIC Case Mgt	VIC TAS	NSW ACT	SA NT	WA	QLD	AUST
Clinicians			20,000	26,000	7,000	7,500	15,000	75,500
Medical students			4,500	5,500	1,600	1,500	3,100	16,200
Medical Schools			4	7	2	2	4	19
Clients								
Contacts			440	560	160	160	320	1,640
Follow up		550		700	200	200	400	2,050
Case Management		48						48
Number of Persons Involved								
Volunteers			15	15	10	10	15	65
Board Members	8		8	8	5	5	8	42
Admin	1	1	1	1	1	1	1	7
Psych Case Mgrs		2						2
Clinical Staff		1						1
Medical Director		1	1	1	1	1	1	6
Days per week								
Admin Support	1.0	1.0	2.25	2.5	1.0	1.0	1.5	10.25
Projects	1.0							1.0
Psych Case Mgrs		8.0						8.0
Clinical Staff		3.0						3.0
Medical Director	0.5	0.5	1.5	1.75	1.0	1.0	1.0	7.25
Effective Hours Worked per Annum								
Volunteers			800	1,120	320	320	640	3,280
Board Members	64	-	64	64	40	40	64	336
Admin	416	416	936	1,040	416	416	624	4,264
Projects	416							416
Psych Case Mgrs	-	2,330	-	-	-	-	-	2,330
Clinical Staff	-	874	-	-	-	-	-	874
Medical Director	208	208	624	728	416	416	416	3,016
	1,104	**3,827**	**2,504**	**2,952**	**1,192**	**1,192**	**1,744**	**14,515**

Table 13: Model annual costs structure – options A and B

Annual expenditure	National Direct' $000	VIC Case Mgt $000	VIC TAS $000	NSW ACT $000	SA NT $000	WA $000	QLD $000	AUST $000
HR Costs								
Volunteers	-	-	6.0	6.0	4.0	4.0	6.0	26.0
Board members	3.2	-	3.2	3.2	2.0	2.0	3.2	16.8
Admin	18.7	18.7	42.1	46.8	18.7	18.7	28.1	191.9
Projects	20.8	-	-	-	-	-	-	20.8
Psych case mgrs	-	186.4	-	-	-	-	-	186.4
Clinical staff	-	109.2	-	-	-	-	-	109.2
Medical director	41.6	41.6	124.8	145.6	83.2	83.2	83.2	603.2
Total HR	**84.3**	**355.9**	**176.1**	**201.6**	**107.9**	**107.9**	**120.5**	**1,154.2**
Purchased services								
Office rental colocation	8.6	29.9	12.7	14.3	6.8	6.8	8.6	87.8
Office exp colocation	4.3	15.0	6.3	7.2	3.4	3.4	4.3	43.9
Legal acct' ins	4.2	8.9	8.8	10.1	5.4	5.4	6.0	48.8
IT and equipment	6.3	13.3	13.2	15.1	8.1	8.1	9.0	73.2
Education			40.0	70.0	20.0	20.0	40.0	190.0
Call centre	10.0							10.0
Phone	1.0	3.6	1.5	1.7	0.8	0.8	1.0	10.5
Computers	1.3	2.3	2.0	2.2	1.0	1.0	1.3	11.2
Travel	5.0	2.5	5.0	5.0	5.0	5.0	5.0	32.5
Advertising			20.0	26.0	7.0	7.5	15.0	75.5
Total services	**40.8**	**75.5**	**109.5**	**151.6**	**57.6**	**58.1**	**90.4**	**583.4**
Total expenses	**125.2**	**431.4**	**285.6**	**353.2**	**165.5**	**166.0**	**210.8**	**1,737.7**

Table 14: Unit costs – options A and B

Annual	National Direct'	VIC Case Mgt	VIC TAS	NSW ACT	SA NT	WA	QLD	AUST
Contacts as % of medical professionals			1.8%	1.8%	1.9%	1.8%	1.8%	1.8%
Cost per contact			$649.2	$630.7	$1,034.3	$1,037.5	$658.9	$796.5
Cost per medical professional			$11.7	$11.2	$19.2	$18.4	$11.6	$14.2
Cost per case managed		$8,986.9						

There is an economy of scale in the average cost per medical professional across the states and territories. The smaller states in terms of medical professionals (SA and WA) have a higher larger unit cost per professional. There is a fixed cost for admin and medical staffing. The cost of education is based on the number of medical schools not the number of professionals. The gross cost budgeted for SA and WA is less than the submission made by SA and less than 50% of the cost of the gross budget for NSW. The average days per week for admin and medical director is based on a minimum of 1.0. The service either exists or it does not. This fixed cost plus extra time for the larger states creates a distortion in the unit costs for SA and WA.

Table 15: Modelled annual statistics – option C

Annual statistics model	National Direct'	VIC TAS	NSW ACT	SA NT	WA	QLD	AUST
Clinicians		20,000	26,000	7,000	7,500	15,000	75,500
Medical students		4,500	5,500	1,600	1,500	3,100	16,200
Medical schools		4	7	2	2	4	19
Clients							
Contacts		440	560	160	160	320	1,640
Follow up		550	700	200	200	400	2,050
Case Management		48	62	17	17	36	180
Number of Persons Involved							
Volunteers		15	15	10	10	15	65
Board Members	8	8	8	5	5	8	42
Administration Staff	1	1	1	1	1	1	6
Psych Case Mgrs		2	2	1	1	1	7
Clinical Staff		1	1	1	1	1	5

Medical Director		1	1	1	1	1	5
Staffed Days per week							
Admin Support	1.0	2.0	2.0	1.0	1.0	1.5	8.5
Projects	1.0						
Psych Case Mgrs		4.0	5.0	2.0	2.0	4.0	8.0
Clinical Staff		1.0	1.2	0.5	0.5	0.8	3.0
Medical Director	0.5	1.0	1.0	0.5	0.5	0.8	4.3
Effective Hours Worked per Annum							
Volunteers		880	1,120	320	320	640	3,280
Board members	64	64	64	40	40	64	336
Admin support	416	832	832	416	416	624	3,536
Projects	416						416
Allied health staff	-	1,664	2,080	832	832	1,664	7,072
Clinical staff	-	416	499	208	208	312	1,643
Medical director	208	416	416	208	208	333	1,789
Total hours	**1,104**	**4,272**	**5,011**	**2,024**	**2,024**	**3,637**	**18,072**

Table 16: Modelled annual costs structure – option C

Annual expenditure	National Direct' $000	VIC TAS $000	NSW ACT $000	SA NT $000	WA $000	QLD $000	AUST $000
HR costs							
Volunteers	-	6.0	6.0	4.0	4.0	6.0	26.0
Board members	3.2	3.2	3.2	2.0	2.0	3.2	16.8
Admin	18.7	37.4	37.4	18.7	18.7	28.1	159.1
Projects	20.8	-	-	-	-	-	20.8
Psych case mgrs	-	133.1	166.4	66.6	66.6	133.1	565.8
Clinical staff	-	52.0	62.4	26.0	26.0	39.0	205.4
Medical director	41.6	83.2	83.2	41.6	41.6	66.6	357.8
Total HR	**84.3**	**315.0**	**358.6**	**158.9**	**158.9**	**276.0**	**1,351.6**
Purchased services							
Office rental colocation	6.9	21.2	24.3	10.7	10.7	18.7	92.5
Office exp colocation	3.5	10.6	12.2	5.3	5.3	9.4	46.2
Legal acct' ins	4.2	15.7	17.9	7.9	7.9	13.8	67.6
IT and equipment	6.3	23.6	26.9	11.9	11.9	20.7	101.4
Education		30.0	52.5	15.0	15.0	30.0	142.5
Call centre	10.0						10.0
Phone	0.2	0.5	0.6	0.3	0.3	0.5	2.3
Computers	0.2	0.7	0.7	0.3	0.3	0.6	2.8
Travel	5.0	5.0	5.0	5.0	5.0	5.0	30.0
Advertising		20.0	26.0	7.0	7.5	15.0	75.5
Total services	**36.3**	**127.4**	**166.2**	**63.4**	**63.9**	**113.6**	**570.8**
Total expenses	**120.6**	**442.3**	**524.8**	**222.3**	**222.8**	**389.6**	**1,922.4**

Table 17: Unit costs option C

	National Direct'	VIC TAS	NSW ACT	SA NT	WA	QLD	AUST
Cost per initial contact		$1,005.3	$937.2	$1,389.4	$1,392.6	$1,217.5	$1,172.2
Cost per medical professional		$18.1	$16.7	$25.8	$24.8	$21.5	$21.0

Table 18: Setup costs

	National	VIC	VIC	NSW	SA	WA	QLD	AUST
Annual	**Direct'**	**Case Mgt**	**TAS**	**ACT**	**NT**			
Set-up costs	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Legal incorporation	$10.0		$7.5	$10.0	$7.5	$10.0	$10.0	$55.0
Equipment option A & B		established	established	$15.0	established	$15.0	$15.0	$45.0
Equipment option C		established	established	$25.0	$10.0	$25.0	$25.0	$85.0

13. MANAGING POTENTIAL CONFLICTS

The potential impact of medical professional impairment on patient safety and for perceptions of a clash of roles and responsibilities between the Board's regulatory role and its provision of funding for doctors' health programs need to be addressed in a highly reliable and transparent manner.

We do not think there is a significant risk of conflict, or perceptions of conflict, associated with Board funding of the core services we identified earlier in this report. To ameliorate any risk, the structure, purpose, activity and accountability of all Board-funded programs should be entirely transparent to the public.

There is, however, a clear risk that Board-funded case management and related services will (or will be perceived to) inappropriately displace regulatory oversight of doctors who have engaged in notifiable conduct or whose conduct would otherwise warrant investigation by the Board. This risk can be mitigated by doctors' health programs implementing robust and transparent procedures for accepting medical professionals onto case management programs, ensuring quality service delivery within agreed treatment parameters, implementing appropriate review processes, ensuring strict legal compliance and communicating effectively with the Board. These are, effectively, clinical governance responsibilities.

While ensuring effective leadership and control of clinical services (i.e. good clinical governance) is a critically important responsibility for the governing body of any organisation that delivers clinical care, it will be a particularly important responsibility for organisations delivering Board-funded case management services. Clinical governance responsibilities apply to clinicians, managers and directors of organisations delivering clinical services, but ultimately the boards of governance of funded organisations will be accountable to the Board for ensuring:

- Board funding is applied as intended;
- clinical services are evidence-based;
- the boundaries of appropriate service provision are both defined and adhered to;
- clinical services do not attempt to substitute for regulatory oversight when it is required by law;
- appropriate data are collected;
- clinical outcomes are monitored and evaluated and expected outcomes are achieved;
- protocols for mandatory notification are both effective and complied with; and
- program effectiveness is evaluated.

For consistency and effectiveness of clinical governance, we recommend the Network leads development of a clinical governance framework, including a specific module addressing the provision of case management and related services. The Board should require all funded organisations to implement the framework, as a condition of funding. The framework should include:

1. Descriptions of:
    - 1.1. the dimensions of service quality (e.g. equity of access, provision of evidence-based clinical services, service safety, service effectiveness, privacy and confidentiality etc.);
    - 1.2. compliance obligations of providers and in particular legislated thresholds for notifiable conduct.

2. Protocols addressing:
    2.1. training of service providers, including compliance training;
    2.2. documentation and data security;
    2.3. privacy and confidentiality including the circumstances in which obligations to the Board will override a medical professional's right to privacy and confidentiality;
    2.4. making mandatory notifications.
3. Protocols for the provision of case management and related services, including:
    3.1. criteria and processes for decision-making about acceptance onto case management programs;
    3.2. the form of case management agreements;
    3.3. assessment of whether reporting thresholds under the National Law have been met;
    3.4. decision-making about changes in conditions of monitoring;
    3.5. management of breach of conditions by participants;
    3.6. management of participants' return to work including communication with employers; and
    3.7. completion of and exit from the program.
4. Standards for:
    4.1. peer review, audit and continuous quality improvement;
    4.2. risk management including adverse event management.
5. A national performance framework incorporating:
    5.1. a single national activity and clinical data set, for collection by all programs and collation by the Network;
    5.2. a comprehensive suite of performance indicators agreed with the Board;
    5.3. a schedule of reporting to the Board via the Network.

As noted earlier in this report, there is some criticism of the provisions in the National Law that require treating doctors in most jurisdictions to notify the Board when a registered medical practitioner has engaged in notifiable conduct even though they have presented for assistance and are willing to voluntarily cease practice while receiving treatment. We understand the basis for this criticism, but we also consider it imperative that the protocols in place for entry into case management programs provide for a complete history to be taken and notification to be made if the mandatory notification threshold is reached. It would be inappropriate for the notification obligation to be avoided, for example, by avoiding asking questions that may lead to disclosure by the practitioner of relevant information about notifiable conduct. For maintenance of Board and public confidence, processes for seeking relevant information from presenting medical professionals and applying it in accordance with the law must be transparent and highly reliable.

We also note that critical decisions about the care of individuals are made at entry to case management, when conditions of monitoring are changed, when there are breaches of conditions and when participants exit programs. We suggest the clinical governance framework provides for team-based approaches to decision-making and/or peer review/audit of decisions at these critical points.

The framework should be submitted to the Board for endorsement, and once endorsed its implementation should be incorporated as a condition of funding of doctors' health programs.

To enhance public, professional and Board confidence, we suggest a high degree of transparency in relation to these arrangements. The clinical governance framework and associated protocols should be accessible to the public.

We also suggest that the organisations funded by the Board to provide external doctors' health programs should not provide additional non-Board funded services unless the Board is satisfied that

the clinical governance of the services it funds will not be diminished as a result of an expansion of scope of services. The Board should be informed of proposals to provide a broader range of services than those it funds directly, and its consent should be sought but not unreasonably withheld.

Recommendation 15

That the Board:

- requests the Network to develop a national clinical governance framework that meets the specifications defined in this report;
- requires implementation of the framework as a condition of funding of external doctors' health programs; and
- as a condition of funding, requires organisations to seek its consent before providing additional services not funded by the Board, such consent to not be withheld unreasonably.

We also believe that confidence in the integrity of case management and related services will be enhanced by establishing highly effective communication between the Board and external doctors' health programs. We refer to the UK GMC's memorandum of understanding with the National Health Service Practitioner Health Programme (**"PHP"**)[54], the purpose of which is to ensure that effective channels of communication are maintained between the PHP and the GMC when information needs to be exchanged. This memorandum of understanding identifies the following areas in which information may be exchanged between the two organisations:

- "In principle" discussion – discussion about how best to manage concerns about a doctor and whether the regulator would need to be informed. In these cases normally the discussion will take place on an anonymised basis[55].
- Point of referral discussion – discussion regarding concerns about individual doctors on the point of referral to either body, where there are concerns about public protection or the safety of patients under the care of the doctor. These discussions will establish how best to progress the case. In these cases the discussion may need to take place on a named doctor basis.
- Post-referral discussion - discussion regarding concerns about individual doctors after one of the bodies has received a referral, to avoid unnecessary duplication and to coordinate activity where appropriate.
- Sharing method development, policies and procedures in relation to the assessment and supervision of doctors who are unwell.
- Communications and educational initiatives.
- Evaluation and research.
- Access to specialist expertise.

The memorandum of understanding expands on the expectations of both parties and the appropriate approach to such discussions.

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54 Accessed on 10 January 2014 at http://www.gmc-uk.org/about/partners_index.asp.

55 We note the Board's preference not to engage in such discussions, but to refer inquirers to their legal advisors or medical indemnity insurers.

We support the development of a standardised protocol addressing communication between the Board and each externally funded doctors' health program, similar to the memorandum of understanding described above.

Recommendation 16

That a protocol detailing the communication obligations of the Board and external doctors' health programs is developed and included in the agreements between the relevant parties.

During consultation for this project we were advised that external doctors' health programs are receiving and responding to an increasing number of inquiries about mandatory notification obligations under the National Law.

We consider there are some risks in assuming this advisory role. While doctors involved in the delivery of external doctors' health programs would be expected to have a good working understanding of the National Law, generally they are not lawyers. Further, external doctors' health programs should avoid any possibility of contributing to perceptions of conflict between their mission to support the health and wellbeing of doctors and their obligation to ensure compliance with the National Law.

The Board advised us that when it is approached for such advice it provides high level advice only and refers inquirers to medical indemnity insurers or lawyers for further, specific advice. The Board has developed written information on the relevant provisions which it provides to inquirers.

In our view, while it is appropriate for external doctors' health services to distribute information prepared by the Board to persons inquiring about their notification obligations under the National Law, individuals seeking further advice should be referred to their organisational lawyers and/or medical indemnity insurers.

Recommendation 17

That the Board requires external doctors' health programs to refer individuals seeking specific advice about the National Law to their own legal advisers and/or indemnity insurers.

14. AGREEMENTS AND REPORTING ARRANGEMENTS

14.1 Introduction

We were asked to advise on:

- the type of agreement (e.g. contract, memorandum of understanding etc.) that AHPRA, on behalf of the Board should enter into with the external doctors' health program/s;
- what elements the agreement should include, including the definition of accountabilities for the external doctors' health program/s; and
- options for the reporting relationships between the Board/AHPRA and the external doctors' health program/s.

14.2 Contracting options

There are two contracting options for the Board with respect to external doctors' health programs. The first is to contract directly with the five service delivery organisations and with the Network. The second is to appoint the Network as a fundholder and authorise/require it to enter into a funding and service agreement with each participating service delivery organisation.

Although the latter option offers some attractions in that the Board would only need to negotiate with a single party, we recommend that the Board contracts directly with each external doctors' health program, rather than via a fundholder. This option will enhance the direct accountability of each program to the Board. The administrative burden on the Board can be minimised by standardising:

- the Board's approach to contracting including utilising a template agreement;
- funding in accordance with the recommendations of this report;
- reporting and accountability arrangements, by implementing a standard clinical governance framework in all participating service delivery organisations and chanelling reporting through the Network to the Board.

For stability and to enable adequate time for development of new services, we suggest the Board establishes an initial three year contractual period.

14.3 Funding and service agreements with external doctors' health programs

For clarity and enforceability, we strongly recommend that the Board through AHPRA enters into funding and service agreement/s in the form of contract/s. While a memorandum of understanding can be legally binding, its usual purpose is to provide a brief record of the terms of a transaction as agreed by the parties during a negotiation process, preceding a contract. A contract, however, is a legally binding agreement. If a contract is breached by a party the other parties to the contract are entitled to enforce it or seek remedies under it.

The Board should define and enforce its requirements with respect to the governance and management of the funded services, including requirements for accountability both internally and to the Board, through the funding and service agreement/s.

We recommend that the relevant funding and service agreement/s contain the following key elements:

1. A preamble/background, describing the respective roles of the parties and the purpose and objectives of the agreement.
2. The principles underpinning the Board's funding of external doctors' health programs, as recommended in this report.
3. The commencement date and contractual period.
4. The structure of the service system and the roles of the participants (including the Network and the external doctors' health programs and their expected relationships with each other and the Board).
5. A description of the Board's commitment to liaise and work collaboratively with the doctors' health programs/Network to improve mutual understanding of factors that affect doctors' health and wellbeing.
6. The obligations to be assumed by the Board including:
    - 6.1. the amount of funding that will be provided;
    - 6.2. the timing of payments;
    - 6.3. the notice that will be provided of the Board's intentions with respect to funding following conclusion of the initial funding agreement.
7. The obligations to be assumed by the service delivery organisations, including:
    - 7.1. to provide a specified range of services, in accordance with the recommendations of this report;
    - 7.2. for organisations that are providing case management and related programs, to enter into agreements with practitioners entering those programs in a format agreed with the Board and to manage those services in accordance with a protocol agreed with the Board;
    - 7.3. for organisations that are not providing case management programs, if requested by the Board, to make reasonable efforts to expand their service mix to include case management and related services;
    - 7.4. to utilise the shared services provided by the Network;
    - 7.5. to not provide services in addition to those specified without the Board's consent, which will not be unreasonably withheld;
    - 7.6. to develop specific strategies to improve equity of access by medical professionals in their nominated jurisdiction(s) to doctors' health services and to monitor and report on the level of equity achieved;
    - 7.7. to work collaboratively with other relevant organisations that have the capacity to raise awareness and improve the knowledge of the medical profession and other relevant stakeholders about medical professional health and wellbeing issues;
    - 7.8. to collaborate with the Network and other external doctors' health programs:
        - 7.8.1. to monitor and continuously improve the performance of the service system;
        - 7.8.2. to develop service system capability;
        - 7.8.3. in a system-wide evaluation of the effectiveness of case management services (if implemented);
    - 7.9. to implement the clinical governance framework and the standardised protocols and procedures developed by the Network and endorsed by the Board;
    - 7.10. to report periodically on financial performance, activity and clinical quality and outcomes in accordance with a performance framework endorsed by the Board;

7.11. to comply with the protocol for communication with the Board, as included in the schedule to the agreement; and

7.12. to provide the following plans to the Board:

7.12.1. an initial business plan in a standard format;

7.12.2. a strategic plan (within 6 months);

7.12.3. subsequently, annual business plans.

8. A provision confirming that ongoing funding is conditional on the funded organisation maintaining the organisational governance and membership structures proposed in this report.

9. A provision requiring participating organisations to notify the Board as soon as reasonably practicable of any serious incident or adverse event that may lead to a reduction in Board or public confidence in the integrity of the programs.

10. Provision for referral of medical professionals by the Board to the doctors' health programs under appropriate circumstances.

11. Definition of:

11.1. procedures for dispute resolution;

11.2. the circumstances that may trigger a review by the Board of its funding commitment and the procedures that would be followed by the Board prior to any determination that funding should cease or be altered.

12. The following schedules, which may be amended from time to time by agreement between the parties:

12.1. the endorsed clinical governance framework including the performance framework;

12.2. a protocol addressing communication between the Board and the external doctors' health program(s);

12.3. the Board's funding and service agreement with the Network.

13. Other usual contractual provisions that would apply to an agreement of this type.

14.4 A funding and service agreement with the Network

A compatible funding and service agreement should be entered into by the Board and the Network. That agreement will be simpler than those with the service delivery organisations, because the Network will not be a direct provider of clinical services and governance requirements will, therefore, be considerably less complex. To the extent that the Network is funded to provide shared services, it should be required to provide those services free of charge.

Recommendation 18

That the Board enters into standardised three-year funding and service agreements with each external doctors' health organisation, defining mutual obligations and incorporating a national clinical governance framework, a national performance framework and a protocol defining expectations of communication between the Board and each program.

14.5 Reporting relationships

To enhance Board confidence, program reporting needs to be both timely and comprehensive. Recognising the relatively small size of the national program, however, it also needs to be efficient.

As recommended earlier in this report, we suggest that the Network:

- leads development of a national performance framework incorporating a single national activity and clinical data set; and
- collects and collates agreed performance data and reports on performance to the Board.

The performance framework should define a suite of relevant performance information, which may include, for example:

- de-identified demographic and clinical data about program contacts and participants characteristics (gender, jurisdiction, rurality, student, doctor in training etc.), major presenting problems and referral pathways to the external doctors' health program;
- standardised financial reports;
- standardised activity and quality data across the range of funded services;
- for case management services, a range of specific performance data with a focus on patient safety and legislative compliance, which may include, for example:
    - the proportion of program participants who are also under Board regulatory supervision;
    - known incidence of deviation from case management plans;
    - known incidence of patient safety events;
    - number of known notifications of program participants to the Board;
- results of client satisfaction surveys; and
- service outcomes (including participants safely remaining in or returning to medical employment).

The performance framework should specify the information that should be reported locally, for management and governance purposes, and the information that should be reported to the Network for collation, analysis and reporting to the Board.

We suggest that a quarterly report by the Network to the Board, based on program activity and performance in the second most recent quarter (allowing a quarter for the Network to collect data from participating organisations and compile a report) would be appropriate.

Consideration could be given to publishing these reports, for example on the Network website. We strongly support transparency generally, however we believe some time will be required to develop and implement the performance framework. This potential for publication should be kept under consideration.

As proposed in section 14.3 above, we also recommend that participating organisations be required to notify the Board as soon as reasonably practicable of any serious incident or adverse event that may lead to a reduction in Board or public confidence in the integrity of the programs.

We suggest a regular meeting is also convened between Board personnel and the board of the Network, at least annually, to exchange relevant program information (within the constraints of confidentiality and privacy) and discuss program effectiveness and safety.

Recommendation 19

That the primary reporting relationship of external doctors' health programs to the Board is via the Network, in accordance with an agreed performance framework, but that reporting is also required direct to the Board in the circumstances identified in this report.

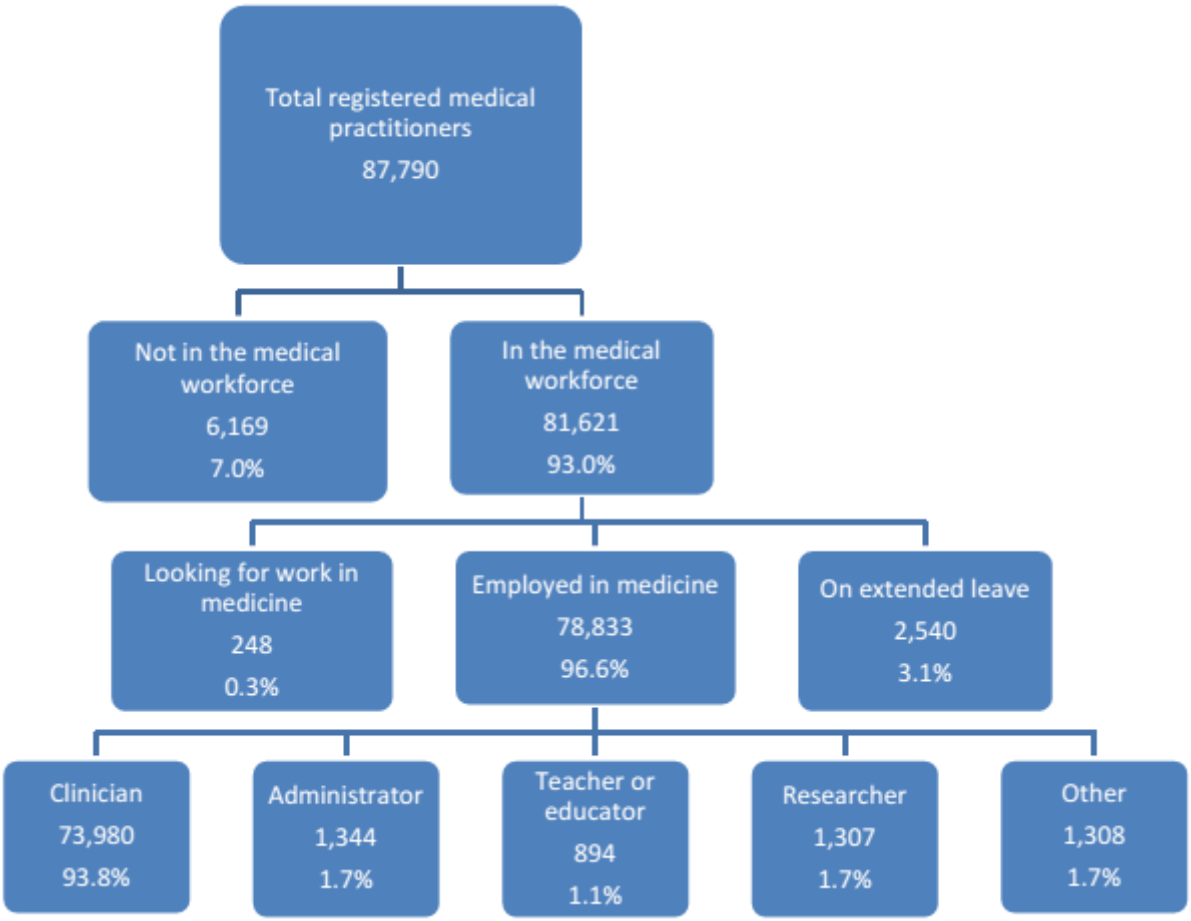
Recommendation 20

That Board personnel meet at least annually with the board of the Network to exchange relevant program information and discuss program effectiveness and safety (within the constraints of confidentiality and privacy).

ATTACHMENT 1 – THE HEALTH PROFESSIONAL WORKFORCE IN AUSTRALIA

Almost 90,000 people work as medical professionals (doctors or medical students) in Australia. At 30 September 2011 there were 87,790 doctors registered in Australia (Figure 1), with 73,980 working as clinicians.

Figure 1: Doctors registered in Australia 2010



Source: Australian Institute of Health and Welfare Medical Workforce 2011

The distribution of clinicians between the States and Territories is shown in Table 1.

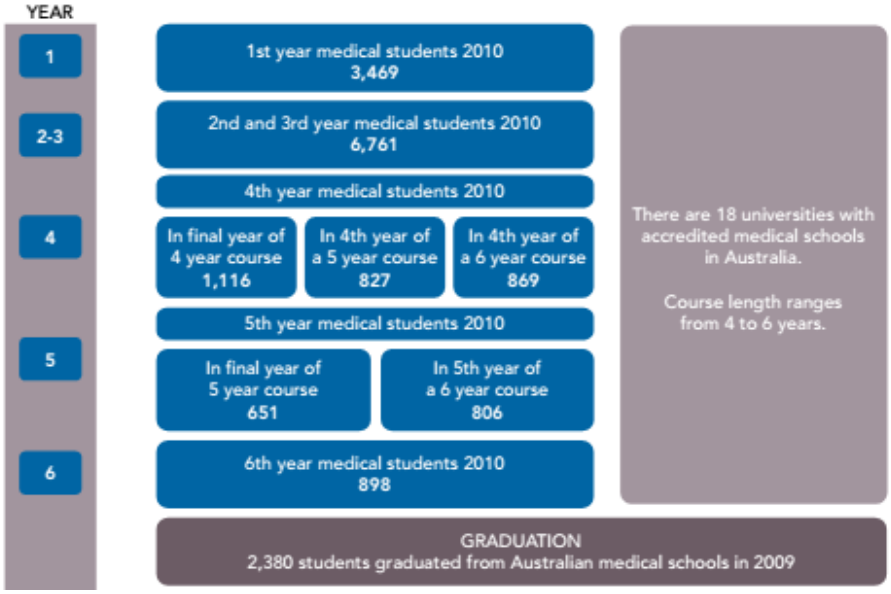
Table 1: Distribution of clinicians employed in medicine (principal role or main job), 2011

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
No of clinicians	23,819	18,106	14,839	7,237	5,963	1,709	1,374	895	73,980 [56]
% of clinicians	32.2%	24.5%	20.1%	9.8%	8.1%	2.3%	1.9%	1.2%	100%

[56] Data include employed medical practitioners who did not state or adequately describe their state or territory, and medical practitioners who reside overseas. Therefore, state and territory totals may not sum to the national total.

In 2010, there were 15,397 medical students in Australia (Figure 2).

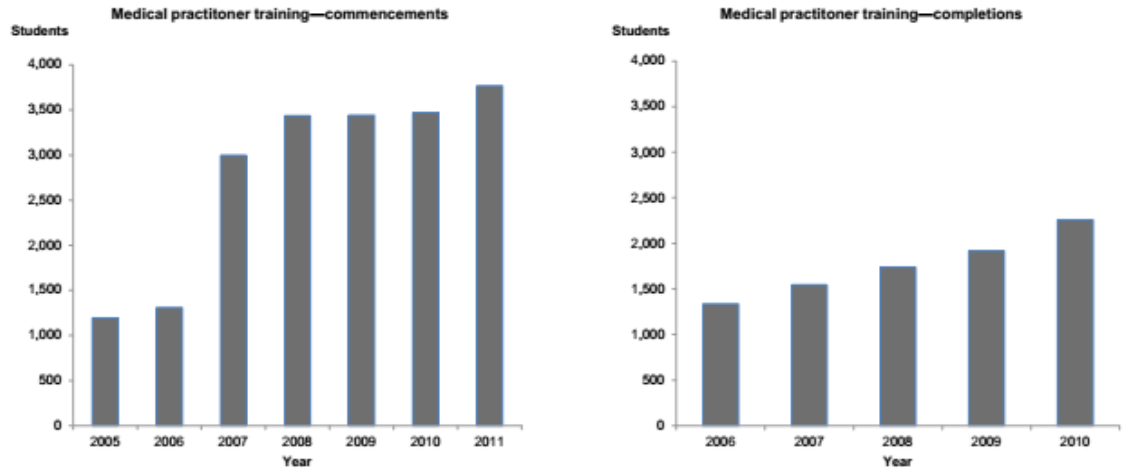
Figure 2: Medical students in Australia 2010



Source: Australia's health workforce series. Doctors in focus (2012).

The size of the medical professional community in Australia is increasing. The number of commencing medical students in Australia more than doubled between 2005 and 2011 (Figure 3).

Figure 3: Number of commencing and completing domestic Australian medical students 2005-2011



Source: Australian Institute of Health & Welfare Medical Workforce 2011

ATTACHMENT 2 – MEDICAL PROFESSIONAL HEALTH ISSUES

14.6 The health status of medical professionals

Doctors who manage their own health and wellbeing appropriately have a greater prospect of positively influencing the health behaviours of their patients[57]. Doctors who suffer ill health may progress to impairment as defined in the National Law, which by definition means there is some (actual or potential) detrimental effect on the capacity of the doctor to practice his or her profession.

While doctors suffer from the same range of health issues as the general community[58], they have also been shown to be physically healthier than the average person in the community. Standardised mortality of doctors has been found to be low in various studies conducted in the United Kingdom and Australia, an outcome often attributed to the generally high socio-economic status and high education status of doctors[59] [60] [61].

According to the Australian Bureau of Statistics ("**ABS**") report on the Australian Health Survey 2011-12[62]:

- Most doctors do not drink alcohol excessively. The 2009 National Health and Medical Research Council guidelines for reducing health risks associated with the consumption of alcohol state that drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury. Around 13% of doctors did drink more than this, but compared with other workers the proportions were much lower (23%).
- Less than 5% of doctors were smokers, considerably lower than the rate for other workers (19%).
- 58% of doctors were overweight or obese, compared with 63% of other workers.

Internationally, more than 90% of Canadian physicians surveyed in 2007 reported being in good to excellent health and only 5% reported that poor physical or mental health made it difficult to handle their workload more than half the time in the previous month (although a quarter had reduced work activity because of long-term health conditions). [63]

It is widely believed, however, that workplace practices and common personal characteristics predispose members of the medical profession to specific health and wellbeing risks. A high prevalence of psychological distress has repeatedly been reported amongst medical professionals. In

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57 Oberg EB, Frank E. Physicians' health practices strongly influence patient health practices. J R Coll Physicians (Edinb) 2009;39(4):290-1.

58 Kay M, Mitchell G, Del Mar C. Doctors do not adequately look after their own physical health. Medical Journal of Australia 2004;181(7):368-370.

59 Carpenter L, Swerdlow A, Fear N. Mortality of doctors in different specialties: findings from a cohort of 20,000 NHS consultants. OccupEnviron Med1997; 54: 388-395.

60 Schlicht SM, Gordon IR, Ball JR, Christie DG. Suicide and related deaths in Victorian doctors. Med J Aust1990; 153: 518-521.

61 Clode, D. (2004) The Conspiracy of Silence: Emotional health among medical practitioners, Royal Australian College of General Practitioners, South Melbourne.

62 http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20April+2013#p10

63 Frank E. and Segura C. Health practices of Canadian physicians. Canadian Family Physician August 2009 vol. 55 no. 8 810-811.

Australia, the following findings were reported from a recent national mental health survey of medical professionals conducted by *beyondblue*[64]:

- doctors reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals;
- young doctors and female doctors appeared to have higher levels of general and specific mental health problems and reported greater work stress;
- the general work experience for Australian doctors is stressful and demanding;
- stigmatising attitudes regarding the performance of doctors with mental health conditions persist;
- medical students reported high rates of general and specific distress in comparison to the general population;
- female students had higher levels of psychological distress and reported more specific mental health diagnoses than male students;
- medical students perceive that there are stigmatising attitudes regarding doctors with mental health conditions; and
- indigenous students appear to be particularly vulnerable to poor general and specific mental health.

These findings are consistent with those of a number of overseas studies that have confirmed higher than expected levels of stress, anxiety and depression amongst doctors[65] [66] [67] [68]. The correlation of these conditions with diagnosed mental illness, however, is not entirely clear. Studies have also shown that while rates of mental illness amongst doctors are similar to those in the general community, rates of suicide are higher, which may be due to higher completion rates[69].

The relatively high observed prevalence of psychological distress has been attributed by some commentators to the demanding nature of medical practice and the often obsessive, conscientious and committed personalities of doctors and medical students[70][71]. A number of studies, including the *beyondblue* study referred to above, have also noted high levels of resilience amongst doctors to the negative impacts of poor mental health.

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64 *beyondblue* is an Australian non-profit organisation which aims to increase awareness and improve the treatment of depression, bipolar disorder, anxiety disorders and related mental disorders.

65 Caplan R. Stress, anxiety and depression in hospital consultants, general practitioners, and senior health service managers. BMJ 1994; 309: 1261-1263.

66 McPherson S. et. al. Stress and coping in accident and emergency senior house officers. Emerg Med J 2003;20:230-231.

67 Newbury-Birch D et. al. Psychological stress, anxiety, depression, job satisfaction, and personality characteristics in preregistration house officers. Postgrad Med J 2001;77:109-111.

68 Sharma A. et. al. Stress and burnout in colorectal and vascular surgical consultants working in the UK National Health Service. Psychooncology. 2008 Jun;17(6):570-6.

69 Centre C, Davis M, Detre T, Ford D, Hansbrough W, Hendin H, et al. Confronting depression and suicide in physicians: a consensus statement. JAMA 2003;289(23):3161-3166.

70 Riley G. Understanding the stresses and strains of being a doctor. Med J Aust 2004; 181: 350–353.

71 Tyssen R. et. al. Personality traits and types predict medical school stress: a six year longtitudinal nationwide study. Medical Education 2007; 41(8):781-787.

14.7 Predisposition to drug and alcohol misuse

The rate of drug misuse by doctors is reported to be the same as for the general population. Because they have access, however, doctors are more likely to misuse prescription drugs[72] .

Studies of junior doctors in the UK suggested a high prevalence of misuse of drugs and alcohol[73]. Two studies of doctors with serious drug dependency brought to the attention of the Victorian Medical Board, in 1964-1984 and 1984-1990, indicated a prevalence of about 0.5%, with GPs and those aged 30-39 years significantly over-represented[74] [75]. An anonymous survey of 1125 doctors in New South Wales suggested drug abuse problems in 1% of those surveyed, a figure closer to estimates from other countries[76]. A study of the characteristics and outcomes of doctors in NSW whose opioid use had triggered official intervention in the period 1985 to 1994 showed similar results to earlier studies - the doctors were mostly male, predominantly in their thirties and had used pethidine. There was an over-representation of GPs and rural doctors. At the end of the 10-year survey period (1985-1994), 13% had died and 46% were no longer on the medical register. Of the 54 that remained on the register, 22 had conditions on their registration.

A more recent study showed that doctors had a lower incidence of high alcohol intake compared to other occupational groups or the general population[77], consistent with the ABS Australian Health Survey results reported above.

14.8 Health seeking behaviour by medical professionals

> *The physician who doctors himself has a fool for a patient.*
>
> Sir William Osler, 1849-1919

It can be seen from the discussion above that it is difficult to make a compelling case for the development of external doctors' health services on the basis of the medical profession having a generally higher need for health services than the general population.

Rather, the main issue of concern is the difficulty medical professionals experience in accessing health care. The case for developing more accessible services is strengthened by the fact that doctors' health practices strongly influence patient health practices (see footnote 15).

Professional colleges[78] [79] [80] and other professional and regulatory bodies[81] [82] encourage doctors to have their own GP.

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72 Wolters Kluwer Health: Lippincott Williams & Wilkins (2013, October 4). "Self-medication": Why doctors abuse prescription drugs. ScienceDaily. Retrieved January 17, 2014, from http://www.sciencedaily.com/releases/2013/10/131004124937.htm.

73 Brooks A. Many junior doctors misuse drugs and drink excessively. BMJ 1998; 317: 700.

74 Serry N, Ball JRB, Bloch S. Substance abuse among medical practitioners. Drug Alcohol Rev 1991; 10: 331-338.

75 Serry N, Bloch S, Ball R, Anderson K. Drug and alcohol abuse by doctors. Med J Aust 1994; 160: 402-407.

76 Pullen D, Cait EL, Lyle DM, et al. Medical care of doctors. Med J Aust 1995: 162: 481-484.

77 Clode, D. Emotional Health: The Conspiracy of Silence among Medical Practitioners. 2004; Royal Australasian College of General Practitioners, South Melbourne.

78 Royal Australasian College of Physicians. Health of doctors. Position statement, May 2013 accessed on 26 December 2013 at http://www.racp.edu.au/page/afoemevent&eventid=16AC340C-0314-0503-705319B51C4EB671.

A national survey of the health and wellbeing of junior doctors conducted in 2008 confirmed that fewer junior doctors (66%) had their own GP compared with the general population (80%)[83]. The survey did not, however, adjust for age, socio-economic status or health status.

358 (40%) doctors responded to a postal survey of 896 Australian doctors randomly selected from the Health Insurance Commission database and stratified by sex, discipline (GP or specialist) and location (urban or rural) in 2001. More participants believed it was acceptable to self-treat acute conditions (315/351; 90%) than to self-treat chronic conditions (88/350; 25%). Nine per cent (30/351) of participants believed it was acceptable to self-prescribe psychotropic medication. A greater proportion of GPs (206/230; 90%) than specialists (101/121; 83%) believed doctors are reluctant to attend another doctor, especially if the problem is psychological. Women and GPs were significantly less likely to report that it was easy to find a satisfactory treating doctor (women, 58/140 [41%]; men, 128/211 [61%]; GPs, 106/231 [46%]; specialists, 80/120 [67%]). Being a specialist was predictive of seeking appropriate healthcare[84].

A research project that explored the attitudes to health access of GPs practising in Australia, and the barriers they experience[85], found that GPs displayed positive attitudes to their own health care but found it difficult to access health care. 58% of the doctors who participated in that study had an independent GP, but self-care (albeit with boundaries) was accepted as normative practice. Some GPs failed to seek treatment even for significant illness. The researchers developed a framework that described the barriers to health care access experienced by this group of GPs (Table 19).

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79 Anaesthesia Continuing Education Coordinating Committee. Welfare of Anaesthetists Special Interest Group. Personal Health Issues and Strategies. Accessed on 1 January 2014 at http://www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists/introduction.html#resources.

80 Royal Australasian College of Surgeons. Surgical Competence and Performance. A guide to aid the assessment and development of surgeons.

81 Australian Medical Association. Health and wellbeing of doctors and medical students – 2011 accessed on 26 December 2013 at https://ama.com.au/node/6551.

82 Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australian accessed on 2 January 2014 at http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

83 Markwell A and Wainer Z. The health and wellbeing of junior doctors: insights from a national survey. Med J Aust 2009 Oct 19;191(8):441-4.

84 Davidson S. and Schattner P. Doctors' health-seeking behaviour: a questionnaire survey. MJA 2003; 179: 302–305.

85 Kay M. et. al. Developing a framework for understanding doctors' health access: a qualitative study of Australian GPs. Australian Journal of Primary Health 2012;18:158-165.

Table 19: Examples of health access barriers for general practitioners

Patient barriers	
No GP	Difficult to choose GP Difficult if no rapport
Lack of time	Concern about inconvenience for their patients Concern about inconvenience for self Failure to prioritise time
Trivialising illness	Never get "sick enough" Don't want to waste GP's time
Mental health issues	Embarrassing More concern about confidentiality GP may not be best option for care
Provider barriers	
Poor quality care	Authoritarian approach Poor communication Over investigation Negative experience
Lack of confidentiality	Professional gossip
	Aware of others breaching confidentiality
	More difficult with practice partner
Professional barriers	
Corridor consultations	More convenient to consult a medical friend
Self-care and health literacy	Reduced need for health care because healthy Already good with preventive health care Effective self-care/treatment Awareness of negative consequences of documentation of illness

Source: Kay M. et. al. Developing a framework for understanding doctors' health access: a qualitative study of Australian GPs. Australian Journal of Primary Health 2012;18:158-165

ATTACHMENT 3 – DOCTORS' HEALTH PROGRAMS AND SERVICES IN AUSTRALIA

Table 20: Key features of external doctors' health programs in Australia

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
ACT Colleague of First Contact									
Sole practitioner	AMA covers telephone costs and promotes service	24/7 on-call telephone advice, referral to an appropriate doctor if required, advocacy with GP and Medical Board, availability for follow-up call if needed, advice to family and other clinicians about managing unwell doctors, advice on mandatory reporting	24	Doctors and the occasional medical student	No	No	Yes – sole practitioner answers phone and refers. Some doctors choose to consult that practitioner privately in which case services are Medicare-billed	No formal budget AMA covers telephone costs	Sole practitioner with high level commitment, no current succession arrangements
Northern Territory									
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
NSW Doctors' Health Advisory Service									
Incorporated association regulated by the NSW Office of Fair Trading	Co-founded by AMA NSW and Medical Benevolent Association of NSW. AMA provides admin. support and telephone answering service	24/7 on-call, telephone advice, referral to an appropriate doctor if required, advice to family and other clinicians about managing unwell doctors, advice on mandatory reporting, provision of training on providing health care to doctors ("Doctors for Doctors"), lectures to medical students, general education sessions Hosting of national website	80-120	Doctors, dentists, vets and students	No	Yes (and hosts national website)	Yes - on-call roster staffed by volunteers	Approx. $18,000 per annum Modest contribution from Australian Dental Association and Veterinary Practitioners Board In the past, has received modest donations	Members of the organisation are doctors with an interest in doctors' health Committee of management comprising ten doctors, a dentist, a veterinarian and a social worker AMA answers the service during the day and takes a message. After hours there is an answering service Approximately

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
									20 GPs involved. GPs are accredited to take calls and use a list published by College of Psychiatrists for referral purposes
Queensland Doctors' Health Advisory Service									
Incorporated association regulated by the Office of Fair Trading, Queensland	Initiated by AMA Qld ("AMAQ"), which continues to provide secretarial and rostering assistance Pharmaceutical companies provide sponsorship for AGM/ educational	24/7 on-call, telephone advice, referral to an appropriate doctor if required, advice to family and other clinicians about managing unwell doctors, advice on mandatory reporting, provision of training on providing health care to doctors,	50-70	Doctors, pharmacists, dentists and students of these professions	No	Yes	Yes - on-call roster staffed by volunteers	Approx. $22,000 per annum, until recently costs borne by AMAQ Some sponsorship by pharma companies and indemnity insurers and some modest donations	Membership consists of ordinary members (unlimited) and representatives of organisations including AMA(Q), state committees/ branches of specialist colleges, Medical

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
	meeting	lectures to medical students, general education sessions						Small fee for service for dentists and pharmacists	Benevolent Association of Qld, the Doctors Group and other organisations as approved from time to time Committee of management is elected from the membership Approximately 40 GPs involved, but the number is reducing Two formal doctors-for doctors training workshops each year

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
Doctors' Health South Australia									
Australian public company, limited by guarantee, regulated by ASIC	AMA (SA) and Rural Doctors' Workforce Agency are founding members Medical Indemnity Group Australia Limited ("MIGA") offers risk management credits to doctors who undergo a Comprehensive Health Assessment	24/7 on-call, telephone advice, referral to an appropriate doctor if required, provision of after-hours clinic-based comprehensive check-ups and referral to a GP for ongoing care, advice to family and other clinicians about managing unwell doctors, advice on mandatory reporting, provision of training on providing health care to doctors (Doctors4Doctors) and general education sessions	43 telephone calls, 143 new patient visits and 214 follow up clinic visits in 2013	Doctors and students	Yes – from private stand-alone consulting rooms		Yes – on-call roster staffed by 6 GP volunteers. Doctors who provide clinic services are remunerated	$338,000 in 2012/13 Revenue offset of $32,837 "sales", $20,070 interest and $13,453 "DHAS contribution" Previously-recognised grant of $332,000 from SA Government consumed in the financial year	Company members are AMA (SA) and RDWA Board composed of 6 doctors and 1 accountant On-line booking system for clinic 44 doctors involved in the community-based network, provided with evidence-based protocols Service orientation is preventive

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
Tasmania									
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Victorian Doctors' Health Program									
Australian public company, limited by guarantee, regulated by ASIC	AHPRA and AMA are current company members	Office-based service (telephone and face-to-face) 9-5 business days, on-call advice service after hours Face-to-face assessment if required, and referral to appropriate doctor if required Case management, after care and monitoring Externally-facilitated support group (Caduceus) Return to work	Approx 200 telephone contacts, 110 consultations Approx. 45 clients under active case management	Doctors and students	Yes - from private rooms located at SVH Melbourne	Yes	Volunteer board Full time- and part time-employed case managers, full time office manager 23 hours per week paid permanent senior clinicians, plus 2 casuals	Approx $500,000	AMA Vic and AHPRA are company members Between 7 and 9 directors appointed by AHPRA and AMA Vic Ltd. A large consultative council nominated by universities, student societies, professional groups, MDOs, funded medical organisations

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
		program Advice on mandatory reporting Advocacy (Medical Board, court, workplaces, family etc.) Lectures to medical students Provision of training on providing health care to doctors and general education sessions							Weekly clinical meeting, case discussions and team decision-making for challenging clients Team review for all case-managed clients at least 6 monthly
Western Australia Colleague of First Contact									
No formal structure. Four GPs and 1 psychiatrist	Informal support provided by AMA including support for conference attendance	24/7 on-call telephone advice provided informally by 4 doctors (no formal roster), referral to an appropriate doctor if required,	30-40	Doctors (approx. 90% of calls) and medical students (approx. 10% of	No	No	No	No dedicated operating budget	Quarterly team meetings to discuss issues

Organisational structure	Organisational partner(s)	Services provided	Approx. number of calls per annum	Client base	Service delivery from physical premises	Dedicated website	Volunteer-based service	Operating cost and funding source	Other comments
	Telephone answering service provided by locum medical service	advice to family and other clinicians about managing unwell doctors, advice on mandatory reporting, general education on doctors' health		calls)					

AMA Victoria Peer Support Service

The AMA Victoria Peer Support Service[86] is a free, confidential service staffed by volunteer doctors who provide telephone support for any Victorian or Tasmanian doctor. It is a "point of first contact" for doctors, experiencing issues such as workplace stress or more serious health issues. It is available between 8 am to 10 pm every day of the year and is staffed by experienced doctors who are "Lifeline accredited", trained in the skills of peer support telephone counselling, have broad experience in medical practice and represent a wide range of specialties.

In 2013, the service received 86 calls.

The service is delivered through three mobile phones which are couriered by the AMA to the doctors commencing their on-call duty. Each mobile phone is equipped with an answering service which allows a message to be left if the on-call doctor is not available. The caller can choose to leave a message or call back.

Caller details are not recorded and callers are encouraged to remain anonymous. If an apparent fitness to practise issue arises, callers are encouraged to contact the VDHP.

Doctors who participate in the on-call roster undergo 24 hours of initial training delivered by a psychologist and meet 5-6 times each year in facilitated meetings to discuss clinical issues on a de-identified basis, and service organisation issues. They are insured by the AMA for their role in the service and receive training from the AMA solicitor in risk management. A psychologist is available to support the participants through debriefing as required and attends their regular meetings as an adviser.

There is a part-time service co-ordinator (1 day per week) who is a senior health care professional. The overall budget for the service is $20,000 per annum, which covers the coordinator's salary, the telephone costs, the psychologist's fees and minor costs associated with meetings. The AMA provides significant 'in kind' support, for example marketing and promotional support.

The service has been operating for 6 years and has been promoted most actively to all Victorian and Tasmanian interns and to AMA members, but is available to all Victorian and Tasmanian doctors.

Are you OK?

Are you OK[87] is an website developed by the Doctors' Health Advisory Service (NSW), the Medical Benevolent Association, the AMA Doctors in Training Group, the Resident Medical Officers' Associations, AMSA, the Clinical Education and Training Institute and the NSW Employee Assistance Program. Its development was funded in 2009 by the Medical Board of NSW. It provides a series of practical tips and tools for junior doctors about health, wellbeing and available services.

Australian Doctors in Recovery

Australian Doctors in Recovery (**"ADR"**)[88] is a mutual support group for doctors in recovery from addiction to alcohol and other substances. It has a 12 step and abstinence focus and is affiliated with

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86 http://amavic.com.au/page/Member_Services/Peer_Support/

87 http://www.jmohealth.org.au/

88 https://www.idaa.org/sites/adr/

International Doctors in Alcoholics Anonymous (**"IDAA"**). Members aim to support each other in healthy living and medical practice free from addictive behaviours.

ADR aims to address the specific support needs of doctors and their families with confidentiality and respect. It acknowledges the need for advocacy and education to dispel the stigma and shame often associated with addictions.

The ADR's principal activity is the annual Australian Doctors in Recovery Convention.

Australian Medical Students' Association

The Australian Medical Students' Association (**"AMSA"**)[89] has undertaken a number of initiatives designed to raise awareness amongst medical students of health and wellbeing issues and strategies to prevent and address poor health and wellbeing, including:

- AMSA Council enacted a comprehensive health and wellbeing policy in March 2010;
- the Get-A-GP Campaign aims to encourage medical students to establish a relationship with a GP, as well as publishing a list of GPs willing to bulk-bill medical students;
- in 2010, AMSA in conjunction with MDA National ran a Health Body Healthy Mind campaign, seeking to raise awareness of the issues affecting medical students and encourage local wellbeing activities;
- in 2011, AMSA in conjunction with the New Zealand Medical Students' Association launched a wellbeing guide for medical students - Keeping Your Grass Greener. This resource is available on the internet;
- in 2012, AMSA ran a national wellbeing campaign and awarded the inaugural AMSA Wellbeing Cup to Flinders University;
- AMSA lobbies universities to provide counselling and support services for students; and
- AMSA, in conjunction with the New Zealand Medical Students' Association, conducted a survey of medical students[90] which showed that 70% of respondents had a regular GP, but this fell to 44% for international students.

CRANAplus Bush Support Line

CRANA*plus*[91] is a membership-based organisation that has the core purpose of educating, supporting and advocating for health professionals working in remote Australia. Originally the Council of Remote Area Nurses of Australia (**"CRANA"**), in 2008 it became CRANA*plus* and extended the opportunity of membership to all remote health professionals and their supporters. CRANA*plus* operates a "Bush Support Line", which is a free, confidential 24-hour, nation-wide telephone service staffed by registered psychologists who have experience working in remote and rural areas. Callers are not required to be CRANA*plus* members and the Bush Support Line is also open to the spouses and family members of remote health workers.

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89 http://www.amsa.org.au/projects/wellbeing/

90 Hillis J. et. al. Painting the picture: Australasian medical student views on wellbeing teaching and support services. Med J Aust. 2010 Feb 15;192(4):188-90.

91 https://crana.org.au/

CRANA*plus* also offers short workshops, internet-based counselling and on-line educational tools designed to assist remote health workers to manage stress, conflict and other issues that affect their health and wellbeing.

National Rural Health Students' Network

The National Rural Health Students' Network (**"NRHSN"**)[92] is a multidisciplinary health network comprising 29 Rural Health Clubs (RHCs) located at Universities around Australia, in every State and Territory. The NRHSN covers medical, nursing and allied health courses, and comprises a member base of more than 9,000 students from the RHCs. The NRHSN is supported financially by the Australian Government.

The NRHSN mental health guide *When the Cowpat Hits the Windmill* is a resource written by students for students, focusing on mental health issues faced by Australia's future rural and remote workforce while on placement or working out bush. It was developed by the NRHSN in conjunction with beyondblue: the national depression initiative, for medical, nursing and allied health students and was launched by The Honourable Jeff Kennett AC at the NRHSN Forum in 2007.

RACGP GP Support Program

The GP Support Program[93] is a free and confidential service offered by the RACGP, which is available to all Australian RACGP members who are registered medical practitioners. The GP Support Program assists RACGP members with a range of issues, including:

- handling work pressures;
- managing conflict;
- grief and loss;
- relationship issues;
- concerns about children;
- anxiety and depression;
- alcohol and drug issues; and
- traumatic incidents.

The service is delivered by psychologists engaged by IPS Worldwide (**"IPS"**), an Australian company with experience in establishing member assistance programs. The counselling methodology adopted by IPS is a short term, cognitive-behavioural approach for the treatment of many types of emotional, behavioural and interpersonal issues. It is a collaborative and individualised program that helps to identify unhelpful thoughts and behaviours and learn or relearn healthier skills and habits.

Face-to-face counselling is available in over 200 rural and urban locations throughout Australia.

The first three consultations are free to all RACGP members who are registered medical practitioners. Additional free counselling may be available, depending on the psychologist's assessment.

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92 http://www.nrhsn.org.au/site/index.cfm

93 http://www.racgp.org.au/yourracgp/membership/extrabenefits/wellbeing/gpsupport/

R Cubed

R-Cubed is a website that provides GP registrars, medical students and pre-vocational doctors with strategies and tools to build resilience. It is an initiative set up by General Practice Registrars Australia (**"GPRA"**) in direct response to feedback from GP registrars and medical students about the pressure they are often under and the need to manage this effectively and stay well. It provides a range of resources including contact information for doctors' health advisory services.

SA Rural Doctors' Workforce Agency 'Dr DOC' program

The Rural Doctors Workforce Agency works closely with Doctors' Health SA to link rural GPs to a range of rural and city-based general health care services[94].

Welfare of Anaesthetists Group

The Australian and New Zealand College of Anaesthetists (**"ANZCA"**) Welfare of Anaesthetists Group[95] was formed to raise awareness of the personal and professional issues which can adversely affect the physical and emotional well-being of anaesthetists and intensivists at all stages of their careers. In 1998 the group became an official special interest group, with ANZCA providing the secretariat. The group is an informative, educative and referral group. It has no therapeutic role. Its work includes:

- educating anaesthetists and trainees in the care of their personal and psychological health, and that of their colleagues, fostering a climate of care, openness and support;
- identifying issues causing stress in anaesthetists' lives;
- establishing guidelines for management of welfare-related problems;
- expanding continuing medical education activities to include education on issues such as lifestyle, mental health, relationships, stress management and personal development, by holding sessions at state and national meetings, one-day seminars, and regional seminars for trainees and trainers;
- developing support strategies within and outside the profession;
- establishing a website, a resource brochure, a resource network and a reading list;
- facilitating access to, and liaison with existing helping agencies including doctors' health advisory services;
- advertising welfare activities and support schemes (in newsletters and the ANZCA Bulletin);
- liaising with ANZCA and other organisations; and
- researching and collecting data.

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94 http://www.ruraldoc.com.au/services/support-for-doctors/health-and-wellbeing/

95 http://www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists

ATTACHMENT 4 - VDHP ASSESSMENT AND CAMP SERVICES

The VDHP's assessment program and its case management, aftercare and monitoring program (CAMP) are based on state- and province-based programs first established in the USA and Canada more than forty years ago[96].

The role of case management is assessment, monitoring, planning, advocacy and linking with rehabilitation and support services[97].

The VDHP employs medical practitioners with relevant qualifications in psychiatry and/or counselling, on a part-time basis. These specialists do not provide ongoing treatment to medical professionals referred to the VDHP. Rather, they provide initial assessment, triage and referral services. While some medical professionals who contact or are referred to the VDHP do not require face-to-face assessment, this is the exception rather than the rule. Most are seen in person by one of the senior employed medical professionals and appropriate referrals are instituted.

All medical professionals who present with alcohol or other drug or mental health problems are referred for appropriate treatment. Participants who do not have their own GP are expected and assisted to find one. The VDHP has also established a network of specialist medical practitioners, other relevant specialists (e.g. psychologists) and a large private psychiatric hospital, to facilitate referrals.

The VDHP also employs a full-time and a part-time case manager, both of whom have relevant allied health qualifications. Where clinically appropriate and consistent with the regulatory framework, medical professionals who have accessed appropriate primary treatment return to the VDHP for case management and relapse prevention through CAMP. Some medical professionals are also referred to the VDHP by private psychiatrists who seek case management support.

Participants are asked to sign CAMP agreements and are then supported and closely monitored by VDHP case managers and senior clinicians in collaboration with treating doctors and, in some cases, with people designated in their workplace (by consent) as workplace monitors.

A CAMP agreement may include a commitment by the medical professional to comply with a range of therapeutic measures which may include ongoing care by a psychiatrist and/or GP, primary monitoring by a VDHP clinician (usually face-to-face, although a lack of resources has led to reliance on telephone contact in some circumstances for rural medical professionals), attendance at the VDHP Caduceus Group (a mutual support group facilitated by professional alcohol and other drug counsellors), attendance at other support groups (e.g. Alcoholics Anonymous) and/or workplace monitoring. Monitoring by the VDHP includes regular hair and urine testing in appropriate cases. Self medication is prohibited for all participants.

A material breach of a CAMP agreement by a participant will result in notification by VDHP clinicians to AHPRA in accordance with the regulatory framework.

The case manager maintains regular contact with the medical professional who is subject to the CAMP agreement, their treating clinicians and the professional's workplace, monitors the participant's clinical progress and adherence to their management plan, reviews urine and hair testing results and provides psychosocial advice and support. The intensity of case management varies but it may involve multiple contacts each week in the early stages of a CAMP agreement or in

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[96] Breen K. Doctors' health: can we do better under national registration? Med J Aust 2011; 194 (4): 191.

[97] http://health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-acc~mental-pubs-p-mono-bas-acc-cas

circumstances of personal or professional stress for the medical professional who is subject to the agreement. Return to work programs also require intensive interaction and detailed negotiation about working conditions between the case manager, the medical professional who is receiving care and the employer.

Case management of medical professionals with alcohol and/or other drug addictions usually continues for at least five years. Case management of medical professionals with mental health problems may be for a shorter period.

The VDHP conducts multidisciplinary clinical meetings at which all medical professionals on CAMP agreements are reviewed closely at least six monthly, or more frequently if necessary.

ATTACHMENT 5 - DOCTORS HEALTH NETWORKS IN USA AND CANADA

United States

The Federation of State Physician Health Programs (FSPHP) is a not-for-profit, independent professional and educational corporation with a membership of 42 state programs, and the following goals:

1. Achieve national and international recognition as a supporter of state physician health programs.
2. Promote the best medical care possible for all patients.
3. Promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians prior to the illness impacting the care rendered to patients.
4. Pursue consistent standards, language, and definitions among state physician health programs.
5. Maintain an organisational structure that will help achieve its vision and mission.

The FSPHP produces a range of publications including policy statements, guidelines and newsletters. It conducts an annual meeting and conference. It serves as an educational resource about physician impairment, provides advocacy for physicians and their health issues at local, state, and national levels, and assists state programs in their quest to protect the public.

In addition, the FSPHP:

- helps to establish monitoring standards;
- facilitates regional educational meetings;
- serves as an informational resource;
- accumulates relevant data on the functioning of state programs, state laws that govern program operation, and resources available for assisting physicians with psychoactive substance use disorders and mental and physical illness.

In an attempt to foster continued communication and understanding between the FSPHP and the Federation of State Medical Boards (FSMB), annual meetings of the FSPHP and the FSMB are often scheduled at the same meeting location to allow participation in both meetings.

Canada

The Canadian Physician Health Network (CPHN), established in 2001, is an alliance of organisations interested in advancing the health and well-being of physicians. Member organisations are responsible for policies, programs and services in physician health. They include the Canadian Medical Association (CMA), provincial/territorial medical associations, provincial physician health programs, the Canadian Association of Internes and Residents (CAIR), the Canadian Federation of Medical Students (CFMS), the Canadian Medical Protective Association (CMPA) and the Association of Faculties of Medicine of Canada (AFMC). The aim of the CPHN is to provide an environment where mutual support, resource sharing and promotion of ideas and innovation on behalf of physician health and well-being can occur. The key activities of the CPHN include:

1. To collect, compile, analyze and evaluate information regarding Canadian physician health and well-being, including physician stress, distress and impairment.
2. To develop a forum in which ideas and experience may be shared and communication enhanced.

3. To facilitate, encourage and promote prevention and early intervention initiatives in order to lessen physician morbidity, burn out, loss or premature enforced retirement.
4. To advocate for and champion initiatives that lead to physician health and wellness.
5. To serve as an expert advisory body to the CMA Centre for Physician Health and Well-being.
6. To liaise with external stakeholders with shared interests including possibly the Federation of State Physician Health Programs (FSPHP), the Federation of Medical Regulatory Associations of Canada (FMRAC), the AFMC Physician Health Resource Group and others as mutually agreed upon.