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20 March 2013

Mr Richard Willis
Senior Secretary
Standing Committee on Legal and Social Issues
Legislative Council
Parliament House
EAST MELBOURNE 3002

Dear Mr Willis

I write in response to your letter dated 14 December 2012, in which you request a response to two matters that were taken on notice during the Department's evidence to the Committee on 8 December 2012. These were:

- The impact of the national registration scheme on Victorian health programs for doctors and nurses, including any related feedback from these professions.
- The draft terms of reference in relation to the intergovernmental agreement requiring a review into AHPRA after three years of operation.

With respect to the first matter, the attachment to this letter provides further information on Victorian doctors and nurses health programs.

With respect to the second matter, I advise that the draft terms of reference for the review of the National Registration and Accreditation Scheme are still to be considered by the Australian Health Workforce Ministerial Council (AHWMC). To obtain a copy, the most appropriate course of action would be for the Chair of the Legislative Council Committee to write to the Chair of the AHWMC.

I trust this advice is of assistance.

Yours sincerely

Peter Fitzgerald
Executive Director
Strategy and Policy

State Government Victoria

health

Victorian Legislative Council Social and Legal Issues Committee

Inquiry into the Australian Health Practitioner Regulation Agency (AHPRA)

Department of Health Briefing Paper

Victorian health programs for medical practitioners, nurses and midwives

20 March 2013

Contents list

Executive Summary

In October 2012, the Victorian Legislative Council asked its Legal and Social Issues Legislation Committee to inquire into, consider and report on the performance of the Australian Health Practitioner Regulation Agency (AHPRA). On 12 December 2012, the Department briefed the Committee, and was requested to provide further information with respect to the impact of the National Scheme on Victorian health programs for doctors and nurses, including any related feedback from those professions.

The Victorian Doctors Health Program (VDHP) and the Nurses and Midwives Health Program Victoria (NMHPV) were established prior to the development of the National Registration and Accreditation Scheme (NRAS), as initiatives of the respective state registration boards. As these stand alone health programs were unique to Victoria, special transition arrangements saw the Victorian boards for medicine and nursing each transfer approximately $1.5 million to AHPRA, to fund the operation of these programs for three years post-transition, to 1 July 2013.

During 2012, the MBA and the NMBA consulted with stakeholders, to determine whether registrant fees should continue to finance these health programs after 30 June 2013. On 16 November 2012, the NMBA announced its decision not to continue funding the NMHPV beyond 2014. On 6 March 2013, the MBA announced its decision to fund a health program or programs for medical practitioners from 2013-14, from within existing resources.

Concerns have been raised about the current arrangements. While case management and monitoring of impaired registrants is considered to be core business of the National Boards, to delegate these functions to an external agency such as the VDHP and the NMHPV blurs the lines of accountability and responsibility, and potentially increases the risk of regulatory failure.

In November 2012, the NMBA announced its decision not to continue funding the NMHPV past 2014. In March 2013, the MBA announced its decision to provide funding for health programs from 2013-13. AHPRA is continuing to work with all National Boards to explore a possible cross-profession approach to external health programs that could complement the National Boards' core statutory role in relation to impairment.

There are a number of mechanisms through which funds raised from registrant fees might be redirected to fund external health programs such as the VDHP and the NMHP. In summary, the options are:

Option 1: The National Board decides to exercise its power under the National Law to fund external health programs from registrant fees.

Option 2: The Ministerial Council agrees to amend the National Law to enable registrant funds to be redirected to fund external health programs.

Option 3: The Victorian Parliament amends the Victorian adoption law to impose a levy on Victorian registrants, to be redirected to fund external health programs.

Option 4: As for Option 3 except rather than a levy, the Victorian law would be amended to enable the first portion of fees collected from Victorian registrants to be redirected to fund external health programs.

1. Introduction

In October 2012, the Victorian Legislative Council asked the Legal and Social Issues Legislation Committee to inquire into, consider and report on the performance of the Australian Health Practitioner Regulation Agency (AHPRA) including the cost effectiveness, regulatory efficacy of and the ability of the National Scheme to protect the Victorian public.

In response to a written request dated 21 November 2012 to the Minister for Health, the Hon David Davis MP, officers from the Department of Health appeared before the Committee on 12 December 2012, to provide a briefing on the purpose of the Inquiry, background to the establishment of AHPRA, and any assistance with possible areas of investigation.

At that hearing, the following matters were taken on notice:

1. The impact of the National Scheme on Victorian health programs for doctors and nurses, including any related feedback from those professions.
2. The draft terms of reference in relation to the intergovernmental agreement requiring a review into AHPRA after 3 years of operation

Below is the Department's response with respect to the impact of the National Scheme on Victorian health programs.

2. Background to the Victorian health programs

Prior to the establishment of the National Registration and Accreditation Scheme for the health professions (NRAS) there was considerable variation across states and territories in the powers of boards to deal with impaired registrants and the resources allocated by boards to this task. In some statutes, mainly those governing the medical profession, there was a clearly defined 'impairment pathway' that enabled registration boards to deal with impaired registrants separately to the disciplinary pathway.

Attachment 1 lists key events in the development of regulatory provisions governing impaired registrants in Victoria. Regulatory powers to deal specifically with impaired registrants were enacted in 1993 with the passage of the *Nurses Act 1993* (Vic) and the *Medical Practice Act 1994* (Vic). Over the next decade these powers were strengthened and codified. Under the (now repealed) *Health Professions Registration Act 2005* (Vic), all Victorian registration boards had powers to deal sensitively and cooperatively with impaired registrants in order to protect the public, while at the same time facilitating their rehabilitation and return to work.

The Victorian Doctors Health Program (VDHP) was established in 2001 as a joint initiative of the Medical Practitioners Board of Victoria (MPBV) and the Australian Medical Association Victorian Branch. It was established to provide assistance to medical practitioners and medical students experiencing stress or anxiety, substance use problems, mental or physical health concerns, or any other health problem.

The services provided by VDHP are listed on its website as: advice and information, finding a GP, assessment and referral, a 'case management, aftercare and monitoring' program (CAMP), assistance with re-entry to work, advocacy, a rural outreach program, and a weekly support group for practitioners with substance abuse problems.

The VDHP develops individual management plans and coordinates treatment, including arranging appropriate referrals to external treatment providers. The website states that VDHP clinical staff do not provide direct treatment to program participants, although the website indicates the organisation runs 'support groups'. Practitioners may self-refer, or be referred by the Medical Board of Australia (MBA), the Victorian Civil and Administrative Tribunal (VCAT), their employer or an educational institution. When the MBA refers an impaired registrant to the VDHP, it may make the practitioner's maintenance of registration conditional on their participation in the CAMP program. Also, VCAT may impose conditions on a medical practitioner's registration that they attend and be monitored by the VDHP.

An equivalent program for nurses, now called the Nursing and Midwifery Health Program Victoria (NMHPV) was established as a joint initiative of the Nurses Board of Victoria (NBV) and the Australian Nurses Federation (Victorian Branch). It provides screening, assessment, referrals, individual support sessions and groups for individuals with health issues related to their mental health or substance use. The NMHPV develops individual management plans and coordinates treatment, supervising aftercare and supporting re-entry to the workforce. Unlike for medical practitioners, there are no health programs specifically targeted for nurses and midwives in other states and territories.

While the VDHP and the NMHPV were modelled on the Impaired Registrants Health Program established by the NSW Medical Board, there were two key differences. First, while the Victorian programs were funded from registrant fees, they were established under their own auspices, separate from the then MPBV and NBV. Second, unlike in NSW, in some cases the MPBV and the NBV would delegate responsibility for monitoring compliance with conditions imposed on an impaired registrant's registration to the VDHP or the NMHPV, rather than carrying out these functions in house.

Under the NRAS, the NSW Medical Council (the successor of the NSW Medical Board) has retained responsibility for handling complaints and discipline for NSW based medical practitioners, and the NSW program continues to be operated in house. It is considered to be a core part of the NSW Medical Council's statutory assessment and monitoring functions with respect to impaired registrants.

While targeted 'doctors' health' services exist in most States and Territories (such as the Doctors Health Advisory Service Queensland and the Doctors Health Advisory Service NSW) these operate with funds from various bodies, primarily professional associations such as the Australian Medical Association and the specialist medical colleges. Only in Victoria has a program managed externally to the registration board been funded primarily from registrant fees. Attachment 2 below provides some comparative data on 'doctors' health services' available in each state and territory, drawn from information presented in the Medical Board of Australia's paper titled *Consultation on the Board funding external health programs. February 2012*.

3. Impaired registrant powers under the National Law

With passage of the *Health Practitioner Regulation National Law Act* ('the National Law'), enhanced powers have been introduced to enable all National Boards to deal with impaired registrants and students in a separate pathway to the disciplinary pathway. Registrant fees have been set at a level to finance this upgraded function.

All National Boards have powers to deal flexibly with practitioners who have a health condition, or whose habitual use of alcohol or other drugs is compromising, or may compromise, their capacity to practise. Provisions allow a National Board to:

- accept a self-referral from a practitioner who is unwell, and enter into an agreement with the practitioner (or their representative) to:
  - Suspend their registration for an agreed period, or
  - Limit their practice via the imposition of conditions on their registration, and/or
  - Accept an undertaking or enter into some other form of agreement
- refer the practitioner to a range of support programs designed to assist with resolution of their health issues and successful return to unrestricted practice if possible
- monitor compliance of the registrant with any agreement reached or conditions placed on their registration.

Staff in the State Offices of the Australian Health Practitioner Regulation Agency (AHPRA) are responsible for providing case management of impaired registrants, with oversight from either a State or Territory Board or a national committee of experts that sit on a sessional basis. The AHPRA IT system supports these enhanced case management and monitoring functions.

The National Law also contains 'mandatory notification' obligations concerning registered practitioners who have a health condition or whose habitual use of alcohol or other drugs is impairing or may impair their capacity to practise. Notifiable conduct includes where a practitioner has practised while intoxicated by alcohol or drugs, or placed the public at risk of substantial harm because of an impairment.

All registered health practitioners are now under a legal obligation to notify AHPRA if they form a reasonable belief that another registered practitioner has placed the public at risk of substantial harm because their ability to practise is somehow impaired.

Employers and education providers are also under a statutory obligation to make a mandatory notification of any registered practitioner or registered student who has an impairment that places or may place the public at substantial risk of harm.

Section 53(1)(n) of the *Health Practitioner Regulation National Law Act 2009* provides powers for a National Board to provide financial or other support for health programs for registered practitioners and students.

4. Transition arrangements for Victorian health programs

As the health programs of the VDHP and NMHPV were unique to Victoria, special transition arrangements were agreed when the NRAS was established. In addition to the general reserve funds that were transferred from each Victorian registration board to the National Scheme, the NBV and the MPBV each transferred approximately $1.5 million to AHPRA, to fund the operation of these programs for three years post-transition.

Following transition, it was expected that the MBA and the NMBA would review the arrangements and decide whether registrant fees would continue to finance their respective health programs after 30 June 2013.

Attachment 1 includes details of the steps that the MBA and the NMBA have taken to address questions about the role of these programs and their funding arrangements. It includes extracts from the National Boards websites about decisions the Boards have taken, and their reasons, and feedback from their consultations.

Details of the MBA's consultations are available at the following website:

http://www.medicalboard.gov.au/News/Past-Consultations/2012/Consultation-February-2012.aspx

The MBA received 92 submissions from stakeholders, most expressing strong support for continuing the VDHP, and extending its scope nationally. A number of submissions raised concerns about the Victorian model (see section 5 below).

Details of the NMBA's consultations are available at the following website:

http://www.nursingmidwiferyboard.gov.au/News/2012-11-15-media-release.aspx

The NMBA engaged Siggins-Miller to undertake a gap analysis between services provided to support impaired nurses and midwives in Victoria, both through AHPRA and the NMHPV, and those services offered in other jurisdictions. The subsequent report titled *Evaluation of health programs for managing impaired nurses and midwives. Report to the Nursing and Midwifery Board of Australia. April 2012* found the following:

> *There was complete agreement about the quality, effectiveness and value of the NMHPV's work. There are no other such Board-related health programs in other States and Territories. ANF branches were enthusiastic about the Victorian model, and argued that a similar program of support for and by impaired nurses and midwives was essential to retain a safe and competent workforce. Some jurisdictional contributors were also attracted to the model, but some had questions about a wider program. They felt the need was not so great as to require more than what EAPs and accessible public and private support services already provided. How it could operate in more dispersed States, and what would be the realistic cost of making it available to rural health services, district nurses, and aged care staff? Participants thought the costs of such an initiative and who should bear them required further exploration and agreement (p.iv)*

5. Concerns about the Victorian model

At the time of transition to the National Scheme, it is understood that the newly established National Boards expressed some reluctance to assume responsibility for funding the two Victorian health programs or to extend these programs nationally. It is understood that their reasons included concerns about offering state-specific programs, perceived additional administrative burden, doubts regarding programs' value to registrants, and the risks associated with legal action against the programs.

While case management of impaired registrants is considered to be core business of the National Boards, there is a strongly held view that to delegate these functions to an external agency such as the VDHP and the NMHPV blurs the lines of accountability and responsibility, and increases the risk of regulatory failure.

The charters of the VDHP and the NMHPV focus on the welfare of the impaired practitioner. The charter of the MBA and NMBA is to protect the public. There is a lack of clarity around the interface between these National Boards and their respective health programs in monitoring impaired registrants.

Reflecting these concerns, in its paper titled *Consultation on the Board funding external doctors' health programs* released in February 2012, the MBA states:

> *The Board does not believe it is in the public interest to delegate its legislated responsibilities for managing impaired practitioners to external health programs. The Board and AHPRA will continue to assess and manage practitioners who are or may be impaired in order to protect the community.*
>
> *Conversely the Board does not believe it is in the interests of the profession or the public for the Board to directly provide an advisory and referral service for medical practitioners with health concerns. Medical practitioners and the community are better served if the roles of the Board and any independent health service are separate, clearly defined and structured to provide distinct but complementary functions* (MBA 2012)

Concerns about the Victorian model of the VDHP are set out in a submission from the Medical Council of NSW to the MBA's consultation. The full submission is at Attachment 6. The Medical Council of NSW states:

> *...the responsibility for regulation with respect to doctors who have health problems should not be delegated to an external body and oversight and monitoring of all doctors deemed to be impaired under the Law should remain with the regulatory authority.....it is the Council's view that what is called case management and monitoring are regulatory functions and should properly be undertaken by the regulatory authority rather than a third party.....The Council understands that there are instances where the VDHP is managing and monitoring an impaired doctor without the knowledge of the State Board. Moreover there is no clear arrangement for the VDHP and no defined criteria or threshold for the VDHP to make notifications to the State Board about doctors it is managing. This raises significant concerns of public safety, given that doctors undertaking workplace chemical monitoring with VDHP who are not known to the State Board would not have conditions on the national register.*

If such doctors were to move interstate, there would be no way of knowing about their health history including any information about non-compliance or breaches of monitoring arrangements. Moreover, the public and employers are not advised of conditions which might be necessary to regulate the doctor's practice, for example, limitations on hours of work or working as the only doctor on site. Such conditions would in NSW, be published on the on-line register and the employer would be advised of these conditions, as they do not relate to the treatment or monitoring of the doctor's health. Under the VDHP proposal, employers would not be aware of such restrictions, making monitoring of compliance more difficulty.

It is the view of the Council that the Board should regulate and manage all impaired doctors who satisfy the statutory definition of impairment and that it is not appropriate to outsource critical functions, such as case management and compliance monitoring to an external health program. Nor is it appropriate for external health programs to undertake any of the regulatory functions that should be undertaken by the Board.

Conclusion: ....the Council submits that the VDHP model involves inherent risk to public safety, as regulatory functions, including case management and workplace and chemical monitoring, are being undertaken by an external body with no statutory responsibility to ensure public protection. Moreover there are no clear or transparent reporting requirements and no mechanism to ensure that AHPRA and employers are aware of health issues.

The Department supports the approach taken by the MBA to address concerns about the current arrangements. The MBA has announced that external health programs will complement the core role of the Board and AHPRA to manage medical practitioners with impairment that may place the public at risk, and that external health programs will not have a regulatory role, but rather, will focus on supporting and promoting doctors' health (See Attachment 4: MBA Media Release 6 March 2013).

6. Current state of play

On 16 November 2012, the NMBA announced its decision not to continue funding the NMHPV beyond 2014 (see Attachment 3).

The NMBA press release advised that AHPRA is continuing to work with all National Boards including the MBA and the NMBA to explore a possible cross-profession approach to external health programs that could complement the National Boards' core statutory role in relation to impairment.

On 14 February 2013, the Australian Nursing Federation (Victorian Branch) (ANF) website announced the ANF campaign to 'Help Save the Nursing and Midwifery Health Program' (see Attachment 5). The ANF is conducting a web based survey of its members, seeking advice on a proposed funding formula for the continuation of the NMHPV.

On 6 March 2013, the MBA announced its decision to fund a health program or health programs for medical practitioners from 2013-14, from within existing resources (see Attachment 4).

7. Options for securing ongoing funding for Victorian health programs

There are a number of options for securing ongoing funding for programs such as the VDHP and the NMHPV. These are outlined below.

Option 1: National Board decides to fund in accordance with section 210(1)(a) of the National Law

Section 35(1)(n) of the National Law provides a function for a National Board, at its discretion, to provide financial or other support for health programs for registered health practitioners and students.

Section 208 establishes the Australian Health Practitioner Regulation Agency Fund (the Agency Fund). Section 209(1)(b) requires that all fees, costs and expenses paid or recovered under the National Law be paid into the Agency Fund.

Section 210 states that payments can be made from the Agency Fund in various circumstances. This includes 'paying any costs or expenses, or discharging any liabilities incurred in the administration or enforcement of the National Law'.

Funding of the VDHP and the NMHPV can be classified as a 'cost, expense or discharge of a liability incurred in the administration or enforcement of the National Law'.

While the National Law provides for the operation of a National Scheme, section 7(3) empowers National Boards to exercise their functions in relation to one participating jurisdiction only. Accordingly, a National Board could resolve to use a portion of Victorian registrants' fees from the Agency Fund to finance the VDHP and the NMHPV.

Option 2: Ministerial Council agrees to amend Part 9 of the Health Practitioner Regulation National Law Act 2009 (Qld)

Part 9 of the National Law deals with finance and sets out the ways in which registrants' fees must be dealt with and how money can be paid out of the Agency Fund, amongst other things. An amendment to Part 9 could enable monies to be paid out of the Agency Fund, to fund programs such as the VDHP and the NMHPV.

Section 13 of the Intergovernmental Agreement sets out how the National Scheme can be altered and how the National Law can be amended. Section 13.1 states that any of the Parties (defined in the IGA to mean each of the States and Territories who are signatories to the IGA) may propose amendments to the other Parties and the justification for seeking them. Section 13.2 then states that the Ministerial Council will consider any proposed amendments and agree to such amendments as it sees fit. If approved, the amendments will be made to the National Law through the Parliament of Queensland in a form approved by the Ministerial Council (section 13.3). All other States and Territories will then incorporate the changes by applying the amendment as a law of their jurisdiction (section 13.4).

Therefore, under this option the Victorian Minister for Health would make a case to all other States and Territories regarding the importance of schemes such as the VDHP and the NMHPV, and why it is appropriate that such schemes be funded from registrants' fees.

Option 3: Parliament of Victoria passes amendments to the Health Practitioner Regulation National Law (Victoria) Act 2009 to impose a levy on Victorian registrants

The National Law is given effect in Victoria by way of the Health Practitioner Regulation National Law (Victoria) Act 2009. This Act applies the National Law as a Victorian law, but it also contains a number of introductory and explanatory provisions which give the National Law particular meaning in the Victorian jurisdiction.

This option involves using regulatory tools that are limited to the Victorian jurisdiction only. For instance, a levy could be imposed on Victorian nurses, midwives and medical practitioners, to be paid in addition to the registrant fees that must be paid by each registrant annually to AHPRA for registration renewal.

A power to impose a levy would require statutory authority. This could be achieved by amending the Victorian Act to allow for a levy to be imposed on Victorian health practitioners for the purposes of establishing and funding health programs directed at practitioners whose ability to practise is compromised due to impairment.

Such a levy would most likely constitute a hypothecated tax, which is a tax generated for a specific purpose which does not become part of the Consolidated Revenue Fund, and would require approval by the Department of Treasury and Finance.

AHPRA has offered to act as a 'post-box' for collection of such funds, and to redirect them as required. Further work would be required to identify how the funds would be collected, how long they would be held for, the arrangements for dispensing them and for what specific purposes.

Such an amendment to the Victorian Act to authorise redirection of registrant fees for a purpose only to be implemented in the participating jurisdiction of Victoria is technically possible. However, it goes against the aims of the National Scheme and without Ministerial Council approval would constitute a breach of the COAG Intergovernmental Agreement that underpins the National Scheme.

Option 4: Parliament of Victoria passes amendments to the Health Practitioner Regulation National Law Act 2009 (Vic) to redirect first portion of Victorian registrant fees to health programs

This option is a variation of Option 3. Under this option, the Health Practitioner Regulation National Law (Victoria) Act 2009 would be amended to provide for an apportionment of the registrant fees collected from Victorian based registrants (those whose principal place of practice is in Victoria), with the first portion to be redirected in accordance with a Ministerial directive for the specific purpose of funding for health programs.

8. Conclusions

There is a need to resolve the issues associated with funding of the VDHP and the NMHPV as a matter of urgency, in order to give certainty to the parties involved, including those impaired registrants who are receiving services from these programs.

AHPRA has advised that it is working with all National Boards including the MBA and the NMBA to explore a possible cross-profession approach to external health programs that could complement the National Boards' core statutory role in relation to impairment.

A number of mechanisms are available to provide for funds raised through registrant fees to be redirected to fund these external health programs. Whatever decisions are made, the concerns associated with the operation of these schemes vis a vis their interface with their respective registration boards must be addressed, in order to reduce the risks of regulatory failure associated with current arrangements.

Attachment 1: Key events in regulation of impaired medical practitioners, nurses and midwives in Victoria

Date	Event
1993	*Nurses Act 1993* (Vic) passed, providing the following powers for the Nurses Board of Victoria to deal with impaired registrants: • require a registered nurse to undergo a medical examination • enter into an agreement with an impaired nurse for the imposition of conditions on their registration • conduct either an informal or formal hearing.
1994	*Medical Practice Act 1994* (Vic) passed, providing powers for Medical Practitioners Board to deal with impaired medical practitioners as for Nurses Act.
2000	Victorian Doctors Health Program (VDHP) established, modelled on NSW Medical Board's Health Program, except under an auspice external to Medical Practitioners Board of Victoria.
2005	Nurses and Midwives Health Program Victoria (NMHPV) established, modelled on VDHP.
2005	*Health Professions Registration Act 2005* (Vic) enacted, further codifying powers to deal with impaired registrants, through a pathway that is clearly separate from how matters of conduct or performance are managed.
1 July 07	*Health Professions Registration Act 2005* (Vic) comes into effect.
1 July 2010	Commencement of *National Health Practitioner Regulation National Law (Victoria) Act 2009*. National Registration and Accreditation Scheme established. Victorian registrants transition with an allocation of 3 years funding through to 30 June 2013 for the continuation of the VDHP and NMHPV.
9 Nov 2011	AHWMC Chair writes to the Nursing and Midwifery Board of Australia (NMBA) requesting the Board consider the continuation of board-funded health programs and its expansion nationally for the nursing and midwifery professions.
16 Dec 2011	AHWMC Chair writes to the Medical Board of Australia (MBA) requesting the Board consider the continuation of board-funded health programs and its expansion nationally for the medical profession.
1 Feb 2012	NMBA writes to Chair of AHWMC advising of its decision to fund an external consultant to undertake a comparative study of the services provided to support impaired nurses and midwives across Australia and to consult stakeholders prior to the Board's decision. Siggins Miller is engaged to undertake the work.

Date	Event
8 Feb 2012	MBA writes to Chair of AHWMC enclosing a consultation paper that addresses the role of Board in funding doctors' health programs. The paper provides comparative data across jurisdictions including data on funding and service levels. MBA releases public consultation paper *Consultation on the Board funding external doctors' health programs*
5 April 2012	MBA public consultation closes. 92 submissions received (see http://www.medicalboard.gov.au/News/Past-Consultations/2012/Consultation-February-2012.aspx)
14 Nov 2012	MBA Communique from 14 November 2012 meeting states: *Feedback from the consultation on external health programs found general support for the idea of external health programs, to complement the Board's core focus on managing impaired practitioners who may pose a serious risk to public safety. However, there was no consensus on the funding for such external health programs and very limited support for an increase in practitioners' registration fees to enable them.* *The Board continues to develop its position on future funding for external doctors' health programs. It continues to explore options in relation to external health programs, while remaining focussed on managing impaired practitioners to protect public safety. As an interim measure, the Board has agreed to extend short-term funding of $350,000 to the VDHP for the 2013/14 financial year, while the Board determines a policy position.* *The Board has not decided on the amount of funds, nor the range of services that it would fund into the future in establishing an equitable approach to external health services nationally. The Board is examining funding models for external health programs in the context of 2013 budget planning.*
16 Nov 2012	NMBA releases Siggins Miller report and announces its decision: *.the National Board has decided not to fund a profession-specific primary, preventative or support health program nationally or to support ongoing funding of the existing NMHPV. The Board will however:* • *provide an additional year of funding to the NMHPV until 30 June 2014 to support transition* • *continue its focus on improving national consistency in managing notifications about nurses, midwives and students with a health impairment where there is a* • *potential risk to patient safety, and* • *continue to work with AHPRA and other National Boards to implement an education campaign about the mandatory reporting requirements of the National Law, to improve practitioner, employer and education provider understanding about mandatory reporting requirements.*

Date	Event
	AHPRA is also working with the National Boards, including the NMBA to explore a possible cross-profession approach to external health programs that could complement the National Boards' core statutory role in relation to impairment.
Dec 2012	NMBA publishes the following statement in its Newsletter Issue 3 December 2012: *In February 2012, AHPRA, on behalf of the National Board, engaged Siggins Miller – an independent consulting group – to undertake a comparative study on services available to support nurses and midwives with impairment in Australia. In consultation with relevant professional stakeholders as part of the process, the project aimed to provide an overview of health services supporting nurses and midwives with impairment in each jurisdiction, including the Nursing and Midwifery Health Program Victoria (NMHPV).* *The resulting report found limited support for the establishment of a national program for all states and territories. Other states and territories had no similar Board funded health program. Some survey respondents, who were primarily Victorian-based, were enthusiastic about the NMHPV, recommending that similar programs of support helped retain a safe and competent workforce.* *However, other respondents raised questions about the value, need and cost of such a program, which duplicates existing services such as Employment Assistance Programs (EAPs), and other public and private health services accessible to practitioners for support and treatment of issues related to alcohol and other drugs (AOD) and mental health problems.* *While the National Board is concerned about the wellbeing of all nurses and midwives, as a regulator it does not have a statutory role in primary, preventative or support health programs.* *In forming a decision about future National Board funding for the NMHPV, the National Board also considered the range of existing support programs in place across jurisdictions, including EAP programs provided by large employers, and practitioners' access to health support through public and private health sector services.*
14 February 2007	The Australian Nursing Federation (Victorian Branch) commences a compaign to 'Help Save the Nursing and Midwifery Health Program'.
6 March 2013	MBA publishes press release advising of its decision to fund a health program or health programs for impaired medical practitioners.

Attachment 2: Comparison of 'Doctors' health programs

Program	Services offered	Target	Staffing	Workload - initial inquiries 2011 calendar year	Funding
DHAS ACT	Telephone support, advisory and referral service. Some community education components.	Medical practitioners	None. Business and admin support from AMA ACT. Vol mps' provide phone support.	Approx 25-30 calls 2011 calendar yr	Voluntary service. Admin provided by AMA ACT. No costing details available.
DHAS NSW	Telephone support, advisory and referral service. Some community education components.	• Medical practitioners & med students • Dentists, dental students • Vets & vet students	2 NSW AMA staff oversee phone hotline & secretarial services to 2 committees for fee. Vol GPs provide 24/7 phone support.	Approx. 120 calls in 2011 calendar year. Most are stress related.	$40,000. Sources: Previous NSW Medical Board, Veterinary Practitioners Board & Australian Dental Association. AMA NSW subsidizes accommodation & admin support.
DHAS Q	Telephone support, advisory and referral service. Some community education components.	Medical practitioners	No staff. Business support by AMA for $20,000 pa. Management Committee members volunteer. Vol GPs on call per fortnight for telephone counselling	26 calls in 2011 NOTE: Approx 120 calls over 3 yrs (2011 saw difficulties with paging service & no calls for 14 wks)	$20,000 p.a. Sources: Donations, in kind support AMA Qld for business/admin & accommodation for meetings.
DHSA	• Telephone advisory service • Establishing and promoting a choice of dedicated health networks for SA mp's • Education and support of teaching in mp health, incl. Websites & resources to improve self-care • Running accredited training programs for mps' on how to treat mp-patients • Establishing a network of clinical services to provide voluntary checkups for mp's	Medical practitioners		1-2 calls per month 2 training workshops for GPs (approx 50 attendees each)	$49.50 per medical practitioner over 3 years. Source: Reserves of previous South Australian Medical Board.
DHAS WA	Telephone support, advisory and referral service. Some community education components.	Medical practitioners		Approx. 25 calls	AMA WA provides approx $2,000 for travel for convenor to annual meeting/conference. WA locum service covers cost of telephone line & 24 hr telephonist & after hrs locum service. Four voluntary panel GPs & 1 psychiatrist.
VDHP		Medical practitioners and med students		186 initial inquiries → 116 appointments. 331 'follow up' appointments (phone or face to face. 24 program participants attend support group for substance use disorders.	$500,000 p.a. Source: Reserves of previous Medical Practitioners Board of Victoria

Source: Medical Board of Australia *Consultation on the Board funding external doctors' health programs*. February 2012

ATTACHMENT 3

Nursing and Midwifery Board of Australia | AHPRA

Media statement

16 November 2012

National Board position on funding the Nursing and Midwifery Health Program Victoria

The role of the Nursing and Midwifery Board of Australia (National Board) is to protect the public.

In relation to nurses and midwives with impairment, the National Law requires the National Board to focus on reducing risk to the public from nurses and midwives with impairment.

The National Board has considered its role in the ongoing funding of the profession-specific Nursing and Midwifery Health Program Victoria (NMHPV), an independent support health program for nurses and midwives with impairment in Victoria.

When the National Registration and Accreditation Scheme (National Scheme) came into effect on 1July 2010, funds were set aside by the Nurses Board of Victoria for the continuation of the NMHPV until 1 July 2013. The NMHPV is managed independently of the National Board.

'While the National Board is concerned about the wellbeing of all nurses and midwives, and recognises the valuable work of the NMHPV, as a regulator, our core focus must be to protect the public,' said National Board Chair, Ms Anne Copeland.

Having reviewed the NMHPV and other existing support services available to nurses and midwives with health concerns, the National Board has decided not to fund the expansion of a primary, preventative or support health program nationally, nor will it support the ongoing funding of the NMHPV.

However, AHPRA is working with the National Boards, including the Nursing and Midwifery Board of Australia, to explore a possible cross-profession approach to external health programs that could complement the National Boards' core statutory role in relation to impairment.

The National Board considered advice from an independent review that identified that nurses and midwives already have access to existing support services such as:

- Employee Assistance Programs (EAPs) provided by large employers, and
- other public and private health services accessible to nurses and midwives for support and treatment of health problems.

In making its decision, the National Board carefully considered:

- the fairness to all enrolled nurses, registered nurses and midwives of the National Board continuing to fund a service only available in Victoria
- funding implications of establishing and implementing a national health program that provides equitable services across both metropolitan and rural locations in all states and territories, and
- stakeholder concerns that a national rollout of a health program (or other primary/preventative/support health care service) for nurses and midwives may duplicate existing services and have implications for an increase in annual nurses' and midwives'

Australian Health Practitioner Regulation Agency

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ATTACHMENT 4

Medical Board of Australia

Media release

6 March 2013

Medical Board to fund health program/s for doctors

The Medical Board of Australia will fund a health program or programs for doctors from the 2013/2014 financial year, from within existing resources.

The external health program/s will complement the core role of the Board and the Australian Health Practitioner Regulation Agency (AHPRA) which is to manage practitioners with impairment that may place the public at risk. The external health program/s will not have a regulatory role, but rather, will focus on supporting and promoting doctors' health.

"The Board is now focussed on planning what model of external health services it will fund and does not foresee the need to increase registration fees for this purpose," said Medical Board Chair, Dr Joanna Flynn AM.

As a starting point, the Board has clearly defined its role and responsibilities in relation to managing impaired practitioners under the National Law.

"Clear delineation between the regulatory role of the Board in managing impaired practitioners and the role of an external health program in supporting doctors and promoting doctors' health is critical to managing risk to the public and avoiding confusion for practitioners," Dr Flynn said.

One of the principles underpinning the Boards planning for a health program for doctors is to provide equitable access for all practitioners.

"We are committed to establishing a health program for doctors, separate from the Board's regulatory function, that is useful for the profession and accessible fairly to doctors in Australia, wherever they live," Dr Flynn said.

"We are now starting the planning and thinking to make this happen and will keep the profession informed about progress in the months ahead," she said.

The role of the Board: practitioners with impairment

The National Law defines impairment as a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession.

The Medical Board has an important role in relation to practitioners who have an impairment. The Board must assess the risk to the public that the practitioner may pose and if necessary take steps to monitor their health and/or restrict their practice.

Medical Board of Australia

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The Board must comply with the guiding principle of the National Law that 'Boards should only impose restrictions on the practice of a health profession if it is necessary to ensure health services are provided safely and are of an appropriate quality'. In effect, the Board takes a risk-based approach which is non-punitive, and which aims to keep practitioners at work if it is safe to do so.

External health programs

The National Law gives the Board discretion to fund health programs for practitioners and medical students. The National Law defines 'health program' as education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence. The term 'health program' refers to external health programs.

Most Australian states and territories have developed services to assist medical practitioners with health concerns. There is currently significant variation in the type and level of service offered by the existing programs around Australia, ranging from telephone advisory services, through to assessment and case management of practitioners. There is also significant variation in funding of these services. Many operate on the goodwill of volunteers while others have more substantial funding. In two states, doctors' health programs have continued to be funded through registration fees of medical practitioners raised by the state medical boards before the introduction of the National Registration and Accreditation Scheme.

Consultation so far

The Australian Health Workforce Ministerial Council asked the Board to consider continuing the Victorian Doctors Health Program and to expand it nationally. Responding to this request, in 2012 the Board consulted with stakeholders about whether the Board should be funding external health programs for medical practitioners and if so, to what level and what services should be provided.

The feedback from the consultation is published at www.medicalboard.gov.au. There was general support for the Board to fund health services for medical practitioners, but no agreement on what services should be funded. There was a widespread view that any program should be funded from within the Board's current registration fee, rather than requiring a specific fee increase.

For more information

- Visit www.medicalboard.gov.au under *Contact us* to lodge an online enquiry form
- For registration enquiries: 1300 419 495 (within Australia) +61 3 8708 9001 (overseas callers)
- For media enquiries: (03) 8708 9200

ATTACHMENT 5

Home > Campaigns > Save the Nursing and Midwifery Health Program Victoria

Printer friendly version

> Department of Education and Early Childhood Development Nurses Campaign
> Federal ANF campaign: Australia's nurses and midwives. You couldn't be in better hands
> Save the Nursing and Midwifery Health Program Victoria
> 2013 Private Aged Care
> 2012 Private Acute Sector EBA Campaign: Respect Our Work
> 2011 Victorian Public Sector EBA: Nurses, Midwives, Mental Health Nurses, RDNS Nurses: Respect Our Work
> 2011 practice nurses enterprise bargaining campaign
> Taking action on climate change
> Bargaining Agent Authority
> 2008/2010 private aged care campaign: Value aged care nursing properly for better resident care
> Victoria's end of life decisions laws
> Fix WorkCover for injured workers
> 2007-2008 private acute sector campaign: Fund nursing properly for a better state of health
> Don't turn back the clock on nursing education
> 2007 public sector campaign: Fund nursing properly for a better state of health
> Federal Election 2007 your rights at work worth fighting and voting for
> 2010 Victorian State Election

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Resources

Member's newsletter

Help Save the Nursing and Midwifery Health Program

14 February 2013, 11:46am

As members will be aware, the ANF (Vic Branch) has been campaigning to secure ongoing funding for the Nursing and Midwifery Health Program, Victoria (NMHPV) and in late 2012 a reprieve was granted through the Nursing and Midwifery Board of Australia (NMBA) until June 30 2014. Sadly the NMBA decided they are unwilling to fund the NMHPV beyond this date.

The NMHPV provides advice, support, referrals and case management to nurses and midwives and nursing and midwifery students facing the challenges of alcohol, drug and mental health issues.

As an independent service the program has helped hundreds of nurses and midwives suffering drug and alcohol and mental health problems. Employees are often anxious about seeking help from their employer due to the stigma associated with mental health and problems of addiction. This puts them at greater risk of their condition impacting their professional lives and also increases the risk that they may be reported to AHPRA. It is critical that every effort is made to provide nurses and midwives with access to independent health care so they can confidently access support early.

It is critical that we save the NMHPV.

ANF is very concerned that without ongoing funding the NMHPV would be unable to continue to offer its essential services to Victorian nurses, midwives and students of nursing and midwifery. If the program has to close its doors it will be nearly impossible to resurrect.

Recently ANF (Vic Branch) met with Ms Anne Copeland, Chair of the NMBA, about the future of the NMHPV and discussed our opposition to and disappointment in the Board's decision to cease funding.

ANF believes that its decision is not supported by evidence of the program's critical work, provided through feedback from the nurses and midwives who have relied upon the service, and feedback from employers and Directors of Nursing and Midwifery who have gained so much from the resulting workforce benefits.

A recent report released by the NMHPV and produced by The University of Melbourne found that the NMHPV had provided significant casework support and health promotion for nurses and midwives. They found the NMHPV had improved the health of nurses and increased awareness among nurses and midwives and employers regarding the health needs of nurses and midwives.

They suggest there is a strong case for the service to continue into the future.

We have to find a long term solution to resolve the future NMHPV funding problems. Our strong preference has been to have the program totally funded by the NMBA, however the NMBA is refusing to agree to this.

ANF (Vic Branch) has been working on alternative suggestions to put to the NMBA. One proposal is to organise partial funding by the NMBA with a small contribution from each Victorian registrant.

The $560,000 per annum cost required to operate the program (as at 2012) is not prohibitive particularly given the critical services it provides. It equates to around six dollars per Victorian registrant per annum. ANF (Vic Branch) is proposing a joint funding option to maintain the NMHPV beyond 2014. The proposal suggests three to five dollars per annum (5.75 to 6.2 cents per week) increase in registration renewal fees for Victorian nurses and midwives to cover 50% of the cost of maintaining the NMHPV with the other 50% contributed by the NMBA.

We are currently giving members the opportunity to let the ANF (Vic Branch) know if they support this proposal. It is important to emphasise the value the NMHPV brings to nurses, midwives and students of nursing and midwifery when considering this proposal.

Please let us know if you are in support of this proposal so we can press the NMBA to continue funding this important program.

Click here to complete the survey.

If you think you have a problem, or a nurse, midwife or student nurse or student midwife you care about is at risk - call the Nursing and Midwifery Health Program, Victoria

Monday to Friday, 8.30am to 5pm on 03 9415 7551.

ATTACHMENT 6

Medical Council
OF*NEW*SOUTH*WALES

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Our Ref: FF10/083-02 : DD12/05727
Your Ref:

4 April 2012

Executive Officer
Medical Board of Australia
Australian Health Practitioner Regulation Agency
GPO Box 9958
MELBOURNE VIC 3001

By Email: medboardconsultation@ahpra.gov.au

Dear Dr Katsoris,

Re: Consultation on the Board funding external doctors' health programs

I refer to the public consultation paper on Board funding of external doctors' health programs dated 8 February 2012.

I advise that the Medical Council of NSW (the Council) considered the consultation paper at its meeting held on 3 April 2012. The Committee noted that, as part of the consultation, a series of questions have been posed for consideration with respect to the funding of external doctors' health programs.

Do you see any value in, or need for external health programs for medical students and/or doctors? Please explain your reasoning.

It is the view of the Council that a limited external program, such as the NSW Doctors' Health Advisory Service (DHAS), which offers support via its telephone help line and extensive online resources, may have a role as an adjunct to a regulatory program, such as the Council's Health Program. There is a clear distinction between the purely supportive role of the DHAS and the role of the regulatory authority which also affords support but within a framework of public protection as the primary aim.

However, the responsibility for regulation with respect to doctors who have health problems should not be delegated to an external body and oversight and monitoring of all doctors deemed to be impaired under the Law should remain with the regulatory authority. Whilst the consultation paper does not provide detail of the relationship and interface between the Victorian Doctors Health Program (VDHP) and the State Board, the VDHP website states that its services include "Case management, aftercare and monitoring program (CAMP)" and that this includes "workplace monitoring and chemical monitoring".

It is the Council's view that what is called case management and monitoring are regulatory functions and should properly be undertaken by the regulatory authority, rather than a third party. This includes the initial assessment of whether or not the doctor is fit to practise, having regard to the nature of the impairment and if so, what conditions or other restrictions are necessary in order to ensure that the public is adequately protected.

The Council understands that there are instances in which the VDHP is managing and monitoring an impaired doctor without the knowledge of the State Board. Moreover, there is no clear arrangement for VDHP and no defined criteria or threshold for the VDHP to make notifications to the State Board about doctors it is managing. This raises significant concerns of public safety, given that doctors undertaking workplace and chemical monitoring with VDHP who are not known to the State Board would not have conditions on the national register.

If such doctors were to move interstate, there would be no way of knowing about their health history including any information about non-compliance or breaches of monitoring arrangements. Moreover, the public and employers are not advised of conditions which might be necessary to regulate the doctor's practice, for example, limitations on hours of work or working as the only doctor on site. Such conditions would in NSW, be published on the on-line register and the employer would be advised of these conditions, as they do not relate to the treatment or monitoring of the doctor's health. Under the VDHP proposal, employers would not be aware of such restrictions, making monitoring of compliance more difficult.

Of the existing models in Australia as described above, is there a model that you would prefer to see adopted nationally? Is there an alternative model that you would like to see adopted nationally?

The Council submits that the NSW model should be adopted nationally.

As outlined in the consultation paper, the Doctors Health Advisory Service (DHAS) NSW is a relatively economical service which offers personal advice and support via a telephone help line and also provides a wide range of written resources and links via its website.

In NSW, the DHAS is clearly distinguished from the Council's Health Program and it has no role in Council's regulatory functions. The Council's Health Program has been operating under the provisions of the *Medical Practice Act 1992* and now the *Health Practitioner Regulation National Law (NSW)* since 1992, and is the longest established health program in Australia. Since its inception, over 235 doctors have successfully exited the Program, having fulfilled the Council's monitoring requirements. The primary objective of the Health Program is to protect the public whilst maintaining impaired doctors in practice, if it is safe to do so. These objectives are achieved by means of conditions, some of which are publicly available and all of which are available to other State and Territory Boards, should a doctor change his or her principal place of practice.

In NSW, there is a clear and well-defined process for initial assessment and ongoing management of doctors with possible impairment in NSW. When a notification indicates that a doctor may be impaired, according to the statutory definition, the doctor will be assessed by a Council-appointed (independent)

practitioner, often a psychiatrist, who will prepare a report for the Council. If the notification indicates that interim immediate action is necessary in order to protect the public, then the Council will take that action and if necessary, will either suspend or impose conditions on the doctor's practice. The Council's Health Committee will review this report and decide whether to convene an Impaired Registrants Panel Inquiry. Again, interim immediate action can be taken if the report concludes that this is necessary.

In NSW, treatment is undertaken by the doctor's own clinician, with no Council involvement, other than gaining the doctor's authorisation for the treating clinician to notify the Council if the doctor is non-compliant, terminates treatment or fails to attend. The Council does not seek information from the treating doctor, thereby avoiding any conflict of interest or potential to compromise or harm the therapeutic relationship.

Instead, the impaired doctor's progress is monitored by the Council-appointed clinician, who reports regularly to the Council. The Health Committee monitors compliance with the conditions placed on registration, which may require treatment by the registrant's nominated clinician, urine drug testing, restriction of prescribing authority, restrictions as to the nature or scope of practice and regular review by the Council-appointed practitioner and the Council.

By ensuring that all impaired doctors are managed through the Council's Health Program, the Council can at any time, take interim immediate action if this is necessary due to non-compliance or significant decompensation of the doctor. The Council has a statutory duty to ensure public protection. This means that the protection of the public always remains the principal focus during the doctor's involvement in the program, and the potential for other factors to blur this focus, such as treatment and rehabilitation, are minimised.

The Council's Health Program ensures that the Council is informed about all aspects of the doctor. The Health Program integrates with the Council's Performance and Conduct pathways so that decisions in response to a complaint concerning a doctors' conduct or performance can be made with the full knowledge of their health status. This ensures more informed and ultimately better decision-making when managing complaints about doctors.

The strengths of the Council's Health Program include:

- its clear focus on regulation with independent assessment which is distinct from treating relationships
- its philosophy of allowing the treating relationship (or any support sought from external health providers such as DHAS or the Medical Benevolent Society) to remain confidential, which allows a focus on facilitating the doctor to return to good health and minimises the risk that the therapeutic relationship may be compromised
- its acceptance by the profession and other stakeholders, such as medical defence organisations, as a consistent program that fosters cooperation and achieves its public protection goals in a fair and objective way and facilitates treatment and rehabilitation of impaired practitioners
- the action taken being proportional to the level of risk, thereby allowing practitioners to continue working if it is safe to do so

- its structured but non-disciplinary and non-adversarial nature
- its cautious, long term monitoring of impaired doctors
- its flexible integration with all other Council activities such that every decision about a doctor is made in full knowledge of their health status
- its reliance on the mixture of independent opinion and regular face to face review interviews with the impaired doctor provides a sound basis on which to be able to judge whether a doctor should be referred for disciplinary measures because of non-compliance with conditions

Do you believe that it is the role of the Board to fund external health programs?

It is the view of Council that the Board should regulate and manage all impaired doctors who satisfy the statutory definition of impairment and that it is not appropriate to outsource critical functions, such as case management and compliance monitoring to an external health program. Nor is it appropriate for external health programs to undertake any of the regulatory functions that should be undertaken by the Board.

The Council does not consider that it is the Board's role to fund external health programs, but rather to register and regulate doctors. The annual costs of running VDHP, being $500,000, are substantial and an additional cost of $25 per registrant per year is unlikely to be well received by doctors, particularly those in NSW where there is already a comprehensive Health Program run by the Council, which is fully funded from current registration fees.

What services should be provided by doctors' health programs?

The Council's view is that external health programs should provide an adjunct service to programs administered and operated by the regulatory authority. This may include provision of telephone advice, development of a list of practitioners willing to treat colleagues, publication of resources and education of doctors to raise awareness of health issues. Council is of the view that case management (including initial assessment of fitness to practise as a result of the impairment and assessment and determination of the appropriate conditions or restrictions) and compliance monitoring are regulatory functions and should properly be undertaken by the regulatory body.

Conclusion

The Council supports the view that a nationally consistent approach to management of doctors with impairment is ideal. However, the Council submits that the VDHP model involves inherent risk to public safety, as regulatory functions, including case management and workplace and chemical monitoring, are being undertaken by an external body with no statutory responsibility to ensure public protection. Moreover there are no clear or transparent reporting requirements and no mechanism to ensure that AHPRA and employers are aware of health issues.

The Council suggests that the Australian Health Workforce Ministerial Council should be given the opportunity to consider other models, including the model that operates in NSW and in other States and Territories. The NSW model is

accepted by the profession and stakeholders and is recognised for its maturity and success at ensuring public protection whilst maintaining impaired doctors in practice.

The Council would be happy to provide further information to the Australian Health Workforce Ministerial Council if the opportunity arose.

Yours faithfully,

Dr Joanna Hely
Medical Director
Medical Council of NSW