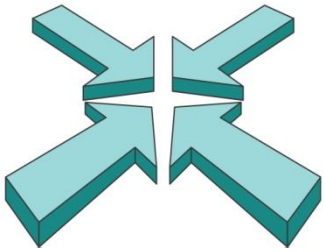
Confederation of Postgraduate Medical Education Councils



Confederation of Postgraduate Medical Education Councils (CPMEC) Ltd

Report of 2010 CPMEC Advisory Council Meeting

2011 Advisory Council Meeting
Auckland, NZ

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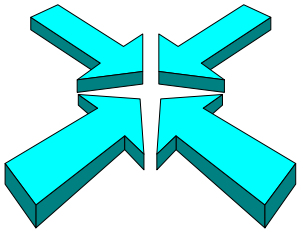
Confederation of Postgraduate Medical Education Councils



2010
CPMEC ADVISORY COUNCIL MEETING REPORT

Held on Sunday, 7 November 2010

Crown Promenade Hotel

Melbourne, Australia

1. IN ATTENDANCE

Present:

Prof B Crotty	PMCV (Chair)
Prof S Willcock	NSW CETI
Prof G Thompson	SAIMET
Dr L Prado	PMCQ
A/Prof T Brown	PMCT
A/Prof E Chalmers	NTPMC
Prof L Landau	PMCWA
Dr A Fraser	MCNZ Education Committee
Ms S Keech	PMCWA
Ms S Bergin	NTPMC
Ms D LeBhers	PMCQ
Ms K Campbell	NSW CETI
Ms C Jordon	PMCV
Ms M Pennicott	PMCT
Mr B Peek	SAIMET
Ms S Yorke	MCNZ Education Committee
Dr J Flynn	MBA
Mr I Crettenden	HWA
Dr M Bonning	AMACDT
Prof R Murray	Medical Deans
Ms L Cachia	DoHA
Ms S-L Jenkins	DoHA
Dr G Keogh	ACFJD Project National Director
Dr T Kimpton	AIDA
Mr R Mokak	AIDA
Ms B Nardi	HWPC
Mr R Roberts-Thompson	AMSA
Ms M Solomon	Medical Deans
Dr R White,	ASCMO
Ms B Wraight	HWNZ
Dr J Singh	CPMEC (Secretary)
Ms D Paltridge	CPMEC
Ms B Butterworth	CPMEC

Apologies:

Ms T Walters	AMC
Dr J Burnand	ACT Health
Dr M-L Stokes	NSW CETI

2010 CPMEC Advisory Council Meeting Agenda

The 2010 CPMEC Advisory Council meeting was structured around key themes of relevance to stakeholders in prevocational medical education and training. Following the report of CPMEC Chair Prof Brendan Crotty, the rest of the meeting was organised around a number of themes as per the meeting agenda below. This report will highlight key points of the presentations and related discussions. Where available, copies of the reports or presentations are included as attachments.

11.30-11.35	Welcome & Introductions Apologies Confirmation of 2009 Council meeting record
11.35 -12.00	***CPMEC Chair's report and discussions*** • Presentation by Prof Brendan Crotty • Discussions
12.00- 12.25	***National Registration and Accreditation for Internship and Prevocational Medical Workforce*** • Presentation by Medical Board of Australia ▪ Dr Joanna Flynn, Chair ▪ Presentation by Debbie Paltridge • Discussions
12.25 – 12.50	***Internships for international students in Australian universities*** • Presentation by Medical Deans ▪ Prof Richard Murray, James Cook University • Presentation by AMSA ▪ Mr Ross Roberts-Thomson, President • Discussions
12.50 -1.05	***Key Developments in Prevocational Medical Education & Training in NZ*** • Presentation by Health Workforce New Zealand ▪ Ms Brenda Wraight, Director, HWNZ • Discussions.
1.05 -1.30	Lunch
1.30- 1.45	***Developing support mechanisms for increase in numbers of indigenous junior doctors*** • Presentation by AIDA ▪ Dr Tammy Kimpton & Mr Romlie Mokak • Discussions
1.45 – 2.25	***Expanding Settings for Internship & Prevocational Training*** • Presentation by GPET ▪ Prof Simon Willcock, Chair, GPET • Presentation by ANZ JMO Committee (ANZJMOC) ▪ Dr Caitlin O'Mahony, National Chair • Presentation by Australian Society of Career Medical

	Officers ▪ Dr Ross White • Presentation by AMACDT ▪ Dr Michael Bonning, President • Discussions
2.25 – 2.55	***Impact of Health reforms on Prevocational medical education, training & workforce development*** • HWPC Presentation ▪ Ms Bronwyn Nardi, Executive Director Clinical Workforce Planning and Development, Qld Health • DoHA Presentation ▪ Ms Lina Cachia & Ms Shara Lee-Jenkins, Medical Education and Training Branch • HWA Presentation ▪ Mr Ian Crettenden, Head of Information, Analysis & Planning Group, HWA • Discussions
2.55 -3.00	• Summary & Concluding remarks by CPMEC Chair

2. CPMEC CHAIR'S 2010 REPORT

Prof Crotty's report to the Advisory Council highlighted the following:

- Changes in the governance structure of CPMEC to a not-for-profit public company.
- Funding for CPMEC continued to be of concern and had adversely impacted on the Australian Curriculum Framework for Junior Doctors (ACFJD) project.
- A Strategic Planning Workshop held on 13 September 2010 had focused on defining CPMEC and PMC's core roles, addressing issues of sustainability, developing a response to national registration and accreditation, and addressing the issues of supervision and training of the prevocational workforce.
- CPMEC had already developed a discussion paper on national internship standards which had called for embedding educational objectives based on the ACFJD into term rotations for interns instead of just focusing on the length or duration of rotations. The paper had also called for the rollout of work-based ACFJD national assessment tools for prevocational doctors
- Internships for domestic students had been largely resolved and the key challenge for the future was finding sufficient number of vocational training places.
- Internships for international full-fee paying students could become an issue from 2012 onwards
- The first national audit multiple job acceptances by interns had allowed for a further 42 intern positions to become available sooner than might have been the case previously.
- There had been good interactions with Health Workforce Australia (HWA) and postgraduate training bodies may be eligible for some funding under the Clinical Supervision Support Program (CSSP)
- There would be a continuing requirement for International Medical Graduates (IMGs) to fill prevocational training positions for several years despite the expansion of Australian medical schools.
- MBA's proposed guidelines for IMGs supervised practice would present capacity challenges.
- CPMEC had raised the issue of extending the Victorian practice of changeover dates and keeping the 'old' registrars for three weeks to ensure/promote safe patient care.
- There was a need to consider streamlining the accreditation of PGPPP positions to reduce the burden on general practices.
- CPMEC was actively promoting vertical integration through regular meetings of CPMEC, CPMC and Medical Deans and through other stakeholder engagements with AMA, AMACDT, AIDA, GPET and others.
- Implementation of the PMAF was underway in each jurisdiction.
- There was significant buy-in for CPMEC's Professional Development Program for Registrars (PDPR) by state and territory health departments and medical training networks
- CPMEC had expanded its awards to recognise outstanding clinical educators throughout Australasia.

Prof Crotty's full report is included as Attachment 1.

3. NATIONAL REGISTRATION & ACCREDITATION FOR INTERNSHIP AND THE PREVOCATIONAL MEDICAL WORKFORCE

Dr Jo Flynn, Chair of the Medical Board of Australia (MBA) noted the following in relation to national internship standards:

- Current state and territory internship registration processes would continue until there was agreement on a national model.
- Accreditation funding to PMCs would be paid on the same basis as in 2010 for the 2011 financial year.
- MBA would focus on the internship year and the process of moving from provisional to general registration.

She further noted that the review of national internship standards had thrown up some fundamental questions such as the very purpose of general registration. John Collins' work on the review of the UK Foundation Programme had also added to the discussions.

Dr Flynn noted that MBA had a two-pronged approach:

- A short-term objective was to ensure transition to a national process for internships
- In the longer term, issues relating to the content and functions of internship would be addressed

Ms Debbie Paltridge, who had been part of an AMC Working Party (with Heather Alexander and A/Prof Tessa Ho) that undertook a series of consultations on internship standards with PMCs, state and territory health departments and the AMACDT made the following observations:

- Questions were raised about what general registration meant in the current system
- There was support for ensuring that training experiences were matched with where actual health care was provided (e.g. primary care and community settings)
- Most respondents expressed strong support for retaining the generalist internship year
- There were mixed views on the role of the PGY2 year
- There was strong support for the ACFJD and the need to implement the national assessment tools developed under the project
- Concerns were expressed about supervisory capacity; support for interns and their supervisors; assessment methods and time requirements; and the need for different levels of supervision.

In discussions, Dr Flynn noted that the MBA was not intending to propose anything that would be fundamentally contradictory to the directions proposed in CPMEC's Discussion Paper on National Internship and Registration. However, she urged everyone to hold fire until MBA defined the policy directions. She also noted that an e-learning portfolio was currently not on the MBA agenda.

CPMEC members urged the MBA to expedite action on the proposed structure as a number of activities were being held up due to uncertainty surrounding national internship standards. This included ongoing funding for the ACFJD project from DoHA.

On a separate question relating to requirements for registration for clinical teachers, Dr Flynn noted that the MBA view was that if there was a requirement that the teaching had to be done by a medical doctor, the person needed to be registered.

4. INTERNSHIPS FOR INTERNATIONAL STUDENTS IN AUSTRALIAN UNIVERSITIES

Prof Richard Murray (Medical Deans) noted the following:

- Medical graduate numbers would increase from 2,264 in 2010 to 3,108 in 2014, with internationals fee paying graduates increasing to 569 by2015.
- Medical Deans were campaigning for internships for **all** Australian graduates and that no further medical schools be opened or there be no significant increase in student numbers until there was sufficient clinical training capacity.
- The Australian health system would continue to be a net importer of IMGs
- HWA funding had been announced but concerns remained over pressures on traditional teaching settings
- It was critical that education and research KPIs were part of the national hospital reforms agenda.
- Medical Deans have commenced a Medical Competencies project which aims to increase clarity (and scope for innovation) in clinical learning.
- In the area of indigenous health, Medical Deans were working on two DoHA funded projects with the Australian Indigenous Doctors' Association (AIDA): A Review of Indigenous Health Curriculum and Framework & Health Futures Project; and hosting a National Forum in 2011 to determine strategies for building capacity of indigenous academic medical leadership.
- The Medical Schools Outcomes Database (MSOD) was proving very useful for medical workforce planning.

In discussions, the following were noted:

- Whilst jurisdictions were expected to find internships for all Australian graduates, it had no powers to cap the numbers of international fee paying students; this could create incentives for universities to increase numbers.
- The displacement of IMGs with international fee paying students was not that simple as many of the IMGs were quite experienced practitioners.
- If the universities had excess capacity, perhaps a case could be made to have more Australian domestic graduates in the first instance.
- International fee paying students tended to avoid the rigorous entry standards into medical programs expected of domestic students.
- Not providing internships to all graduates would result in turning away Australian trained graduates well versed with the healthcare system of this country.

Prof Murray's presentation is included as Attachment 2

Mr Ross Roberts-Thomson (Australian Medical Students' Association - AMSA) noted the key concerns of international students related to the expectations that were created by medical schools. If internships would be difficult to obtain, students should be warned at the commencement of their study programs. Another approach would be to cease increasing medical student numbers. With regard to internship allocation, an AMSA working party had

been set up and had put out a discussion paper that called for an 'easy, efficient and equitable' system.

Mr Roberts-Thomson's presentation is included as Attachment 3

5. KEY DEVELOPMENTS IN PREVOCATIONAL MEDICAL EDUCATION & TRAINING IN NZ

Ms Brenda Wraight, Director of Health Workforce New Zealand (HWNZ) outlined HWNZ's early priorities including the following:

- Integration of workforce development functions – this included an alignment of planning cycles and mitigating mismatches between labour market needs and training funding.
- Recruitment, retention, and repatriation issues. Part of this involved working with the Medical Council of New Zealand to consider changes to provisional registration.
- Innovative programmes to test the utility of new ways of working that improved productivity and quality, reduced costs, empowered the workforce and was nationally sustainable
- Dealing with information, data and using it intelligently to make workforce policy decisions.
- Promoting clinical and health leadership through the NZ Health Leadership Institute.

Ms Brenda Wraight's presentation is included as Attachment 4

6. DEVELOPING SUPPORT MECHANISMS FOR INCREASE IN NUMBERS OF INDIGENOUS JUNIOR DOCTORS

Dr Tammy Kimpton and Mr Romlie Mokak represented the Australian Indigenous Doctors' Association (AIDA) and noted the following:

- AIDA was part of Pacific Region Indigenous Doctors' Congress (PRIDoC) which provided opportunities for sharing knowledge, research, medical information, discussion, partnerships, cultural practices and friendship. AIDA will host the 2012 Congress.
- AIDA had worked with NSW CETI to develop a pilot program aimed at supporting the transition of Aboriginal and Torres Strait Island medical graduates to prevocational training positions in NSW.
- A governance framework to guide future collaboration between CPMEC and AIDA would be highly desirable.
- An area that AIDA considers to be of priority in the prevocational space is graduate support and mentoring. They would like this to become a mainstream activity involving non-indigenous senior clinicians.
- AIDA noted that currently the largest numbers of indigenous doctors are in the prevocational cohort.
- AIDA was also involved in programs aimed at encouraging indigenous children to think about careers in health

In discussions, it was agreed that CPMEC needed to get involved in supporting and mentoring programs for indigenous doctors and consider strategies that PMCs could utilise at the prevocational level given their capacity and resource constraints.

7. EXPANDING SETTINGS FOR INTERNSHIP & PREVOCATIONAL TRAINING
Prof Simon Willcock, Chair of General Practice Education and Training (GPET) Board made the following observations:

- The type of training undertaken by doctors should correspond to the health system that was desired by the community. Given that a great deal of health care delivery was occurring in primary care and community settings, ideally every doctor needed to undertake a community practice rotation.
- By 2013 it was projected that nearly 1000 prevocational trainees would be undertaking training within the primary care setting. This was influenced by a big increase in PGPPP training positions.
- Increased numbers of trainees provided challenges and opportunities including:
    - The need to build clinical supervisory capacity for teaching and assessment, and provide ongoing support and resources
    - Dealing with evolving models of community/general practice such as Superclinics, and the 'Hub and Spoke' model
    - Ensuring alignment and coordination of supervisory incentives
    - Investment in the required training infrastructure and medical education support.

Prof Willcock's presentation is included as Attachment 5

There were two presentations outlining a junior doctor perspective on the issue of expanding capacity. Dr Caitlin O'Mahony, Chair of the ANZJMOC highlighted the need to maintain the quality of training when developing innovative terms. These included clarifying the ACFJD-based learning objectives; access to quality supervision and clinical teaching; compliance with industrial entitlements; and medical indemnity protection.

Dr O'Mahony's presentation is included as Attachment 6

Dr Michael Bonning, Chair of the Australian Medical Association Council for Doctors-in-Training (AMACDT), highlighted the following:

- Internship training had strong oversight through PMCs, but there was less quality monitoring post PGY1.
- There was an urgent need to focus on vocational training capacity as increased graduate numbers flowed through the medical education and training system
- In relation to early streaming, AMACDT preferred a flexible approach that allowed some to fast-track their training whilst allowing to gain more exposure before deciding on a specialisation.
- AMACDT was supportive of community rotations but would not advocate it as a mandatory term.

Dr Bonning's presentation is included as Attachment 7

Dr Ross White, representing the Australasian Society of Career Medical Officers (ASCMO) noted that CMOs welcomed the opportunity to present to the meeting as they had previously not been part of the CPMEC Advisory Council.

On the possible role that CMOs play in prevocational education and training, Dr White listed the following:

- Providing on-the-job training for JMOs in procedural skills
- Communication and handover training
- In hours (especially for surgical JMOs) and after hours support generally
- Direct supervision of JMOs
- Taking on the role of Director of Clinical Training
- Covering wards and ED to allow JMOs to attend compulsory education sessions

Dr White's presentation is included as Attachment 8

8. IMPACT OF HEALTH REFORMS ON PREVOCATIONAL MEDICAL EDUCATION, TRAINING & WORKFORCE DEVELOPMENT

Ms Bronwyn Nardi, on behalf of the Health Workforce Principal Committee (HWPC) noted the following:

- Jurisdictions had to address the issue of workforce shortages in the context of the need to supply health services
- They had to factor in environmental influences such as demographics (e.g. an ageing population)
- There had been a dramatic policy shift in relation to the medical workforce arising from the Productivity Commission report, introduction of national registration and accreditation, move towards local hospital networks, and the establishment of Health Workforce Australia
- There was a potential change in the culture of education with a seeming decline in *pro bono* contributions
- Jurisdictions agreed on the need to focus on Indigenous health issues and HWPC was working with AIDA to map gaps in relation to the Indigenous medical workforce.

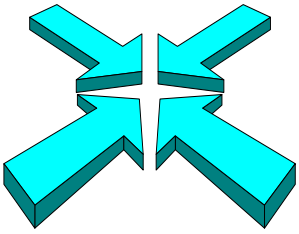
Ms Shara-Lee Jenkins provided an update on behalf of the Australian Government's Department of Health and Ageing (DoHA). Her presentation provided an overview of activities of interest to CPMEC and PMCs including the availability of intern training places and increase in PGPPP training places.

The report from DoHA is included as Attachment 9.

Mr Ian Crettenden, Head of Information Analysis and Planning, Health Workforce Australia (HWA), highlighted the following:

- Supply and demand modelling that was being undertaken to put a set on numbers on the goal of achieving self-sufficiency in the health workforce by 2025
- Developing a National Training Plan by the end of 2011
- A mapping exercise of clinical placements initially at the professional entry level

Report prepared by Dr Jagdishwar Singh
General Manager
CPMEC
6 November 2011



Confederation of Postgraduate Medical Education Councils (CPMEC) Ltd

Chair's Report to the CPMEC Advisory Council Meeting

7 November 2010

Crown Promenade, Melbourne

INTRODUCTION

2009-10 was a year of significant challenges for CPMEC and its member Postgraduate Medical Education Councils (PMC's). Despite uncertainty over long term funding arrangements, CPMEC and PMCs have continued to build on the collaboration that has been evident over the past few years to address key issues in prevocational medical education and training. In this report, I will highlight some of these challenges and the actions taken by CPMEC to address them.

ISSUES IN PREVOCATIONAL EDUCATION & TRAINING IN 2010

a. CPMEC governance

CPMEC has been registered as a not-for-profit public company limited by guarantee. Some of the key components of the new structure include a Board, a Management Committee, a Principal Officers' Committee and Australasian Committees for JMO Forum Chairs, Directors of Clinical Training (or equivalent); and Medical Education Officers. Three priority areas have been identified: Accreditation and Registration*;* Education & Training; and Workforce, each overseen by a PMC Director.

b. Funding of CPMEC and PMCs

Funding for CPMEC continues to be an area of considerable concern; both core funding which allows us to function effectively as the peak body for PMCs and project funding which has not been available since Medical Training Review Panel (MTRP) project funding grants ceased. Further development of the ACF has been delayed by lack of funds. Discussions with HWA, MTRP and the Department of Health and Ageing are continuing.

In consultation with PMCs, CPMEC has developed a paper that identifies national priorities in the prevocational education and training.

c. Strategic Planning Workshop

CPMEC held its 4th Strategic Planning Workshop in Adelaide on 13 September 2010. Discussions focused on: defining CPMEC's core roles and building sustainability; responding to a national approach to registration and accreditation; and recruiting, supervising and training the prevocational workforce.

d. National Registration & Accreditation

Members will be aware that the Medical Board of Australia (MBA) had written to the AMC to provide advice on:

- the standards for intern training;
- what should be expected of interns at the completion of the internship period to enable the MBA to grant general registration; and
- how the AMC might apply a national framework for intern accreditation to the current State-based accreditation processes of post-graduate medical councils to ensure that appropriate and consistent standards are in place for all jurisdictions.

MBA's request was made in response to a CPMEC discussion paper containing proposals on the nature, purpose and duration of the internship; the nature and duration of mandatory clinical experience to be undertaken during the internship; and the sign-off process for satisfactory completion of the internship. The discussion paper recommended that sign off should be based on achievement of rotation learning objectives derived from the Australian Curriculum Framework for Junior Doctors (ACF)

AMC has set up a Working Party to draft the advice to be given to the board. CPMEC's National Project Coordinator for the ACF, Mrs. Deb Paltridge, is a member of the Working Party, which has recently met with PMCs and jurisdictional health departments.

At the moment, the focus of the MBA/AMC work has been on the internship year. However, there has also been a considerable amount of work on the PGY2 year, including a Strategic Study of Postgraduate Training undertaken by the KPMG on behalf of HWA/National Health Workforce Taskforce. Amongst issues to be considered include the value of maintaining a second generalist year, early streaming, recognition of prior learning, impact on service provision, and duration of postgraduate training. CPMEC looks forward to discussions on the role of the PGY2s and their training.

e. Australian Curriculum Framework for Junior Doctors

The Department of Health and Ageing has informed CPMEC that further funding for the ACF will be deferred until MBA makes a recommendation on the role of the framework in progression from provisional to full registration at the end of the intern year. Further development has been postponed pending this recommendation.

Key achievements over the last 12 months include:

- Revision of the ACF to facilitate assessment of achievement of rotation learning objectives. The revised version was launched at the 2009 National Prevocational Forum;
- Development and endorsement of national assessment tools for workplace based assessment;
- Completion of a pilot of the assessment tools at 12 health services throughout Australia. The results of the pilot were reported at the 2009 National Prevocational Forum;
- A new governance structure. The National Steering Group and Assessment Working Party have been retained and three new working parties have been convened; a Teaching and Education Working Party, a Vertical Integration Working Party and a Project Officer Working Party
- The Assessment Working Party has contacted each PMC to establish implementation issues for a national workplace based assessment process.
- The Teaching and Education Working Party has identified web based resources for use by junior doctors and educators in ten ACF topic areas. These resources have been piloted by a group of JMOs and have subsequently been linked with ACF web pages. Resources for another 10 ACF topic areas are under development.
- The Project Officer Working Party implemented a national survey to determine how the ACF was currently being implemented and identify additional support required for implementation. The results of this survey will be presented at the 2010 National Prevocational Forum.

f. Increased Numbers of Medical Graduates

In 2012 there will be 3430 graduates (2912 Australian resident and 518 international full fee paying students (IFFPS)) followed by a gradual increase to 2014 (3786 graduates (3108 and 678)).

The expansion of Australian medical schools has created a requirement for a significant expansion of postgraduate training places with initial priority to expand

intern training capacity. Postgraduate Medical Councils (PMCs) have worked closely with jurisdictional health departments to identify and accredit additional intern training positions, many of which are in settings, which have not previously been used for prevocational trainees. Maintenance of an effective accreditation process has been a challenge in all jurisdictions. The Medical Board of Australia (MBA) has provided short term funding to support intern accreditation.

All medical school graduates with Commonwealth Supported Places (CSP) have been guaranteed an accredited intern year. The issue of internships for international students has received a lot of publicity during the year. CPMEC has been liaising with the Australian Medical Association (AMA), Medical Deans of Australia and New Zealand (MDANZ), and Health Workforce Australia (HWA) to try to find a solution. A position statement has been published on the CPMEC website. CPMEC also participated in an AMA summit that addressed postgraduate training for international and domestic students, and was a signatory to a statement released at the summit.

CPMEC believes that the expansion of postgraduate training should be addressed as a matter of urgency through a more coordinated national approach. Junior doctor workforce requirements are largely determined by immediate service demands at the present time. A more rational approach would also consider the overall medical workforce requirement and use this as a major determinant, not only of intern numbers, but also of undergraduate places and, in turn, vocational trainee numbers. This approach might have implications for recruitment of international students by Australian medical schools

Health Workforce Australia (HWA) has begun to undertake this task and the proposed national training plan to attain self sufficiency is particularly welcome. It will be necessary for HWA and other national agencies to work with both levels of government, medical schools, PMCs, Colleges, medical students and junior doctors to develop the training plan and CPMEC is very willing to assist. CPMEC believes that this plan should be based on an analysis of medical workforce needs over the next decade.

g. National Audit of Internship Acceptances

Under the auspices of a CPMEC Working Party chaired by Prof Geoff Thompson, all jurisdictions agreed to share information on applicants who had accepted 2011 intern positions in more than one jurisdiction. Four jurisdictions - NSW, NT, SA and ACT - agreed to take this process further by contacting applicants who had accepted offers for more than one position and request that they reach a final decision in a timely manner.

With the exception of Queensland, which had a more open opt out pathway, there was a very high participation rate by final year students. A total of 2697 applicants were included in the audit, of whom 41 accepted more than one offer of an intern position (42 positions).

The working party is meeting on November 7 to consider further directions.

h. Health Workforce Australia

CPMEC has been pleased with the rapport that has been established with HWA, and with its CEO, Mr Mark Cormack. Initial funding for infrastructure and capacity have been restricted to professional entry level courses. HWA have signalled that

postgraduate training will be eligible for upcoming Clinical Supervisor Support Scheme (CSSP) and Simulated Learning Environments funding.

i. International Medical Graduates (IMGs)

Despite the expansion of Australian medical schools, there will be a continuing requirement for IMGs to fill prevocational training positions for several years. Assessment and up-skilling of IMGs remains a major challenge for all PMCs and a range of programs have been developed in each jurisdiction.

MBA has proposed new registration standards and guidelines for supervised practice and workplace based assessment for IMGs who have passed the AMC clinical examination. CPMEC and Medical Deans submitted a joint response to MBA Consultation Paper 4 supporting the proposed guidelines but pointing out the challenges that they will create to provide supervisors for both groups.

j. Changeover dates for HMO/Registrars

Victorian CMOs contacted CPMEC because of concerns about resignation of registrars and residents moving to jobs in other states where new registrars start on the same day as new interns. Victoria wishes to continue its current practice of new interns commencing three weeks before the previous year's registrars and HMOs start new rotations. They have argued that this improves patient safety, as the new interns are supervised by experienced registrars for the first three weeks in the job.

After discussion by the MTRP, the issue has been forwarded to the Health Workforce Principal's Committee for consideration at its meeting on 25 November.

k. Joint CPMEC/GPET PGPPP Accreditation Working Party

The Australian government announced a significant expansion of the PGPPP program earlier this year. CPMEC is cognisant of the need to ensure that accreditation of PGPPP positions is not unnecessarily burdensome for the general practices. CPMEC is also mindful that interns and other prevocational trainees undertaking general practice rotations receive appropriate supervision, support and education.

To this end, CPMEC has attended a series of meetings with General Practice Education and Training Ltd (GPET) and representatives of Regional Training Providers to discuss a combined accreditation process for prevocational and vocational trainees.

CPMEC has also compiled an issues paper on PGPPP accreditation articulating the concerns of its members.

l. Vertical Integration

CPMEC has been a strong advocate of vertical integration of training programs. CPMEC, CPMC and MDANZ have commenced regular meetings of the President/Chair and Principal Executive Officers of each peak body and interactions between the three organizations have steadily increased. The Confederation has also contributed to a joint Medical Deans/CPMEC/CPMC proposal to HWA to develop generic supervisor training programs.

m. Prevocational Medical Accreditation Framework (PMAF)

CPMEC has undertaken a survey of its members to gauge implementation of the PMAF in each jurisdiction. The results of this survey will be presented during the 2010 National Prevocational Forum.

n. Professional Development Program for Registrars (PDPR*)*

The PDPR has strong buy-in from clinicians and continues to be supported by state and territory health departments. WA became the latest jurisdiction to start rolling out the program this year. Use of the PDPR to build clinical supervisory capacity was acknowledged in a recent HWA discussion paper.

A Trainer Accreditation Program (TAP) has been developed to support national rollout of the PDPR and ensure its sustainability as a national program.

The PDPR is attracting significant interest from Colleges. CPMEC General Manager, Dr Jag Singh and the CEO of RACP, Dr Jennifer Alexander, made a joint presentation on leadership as part of Trainees Day (March 21) during the World Congress in Internal Medicine. Dr Singh has been invited to make a similar presentation at the RACS Trainees Day.

o. CPMEC Awards

CPMEC has introduced a new award this year to recognise contributions of outstanding prevocational clinical educators. Nominations for the Clinical Educator of the Year in each state and territory are made by junior doctors. Principal Officers choose a National Clinical Educator of the Year from these nominees. The first award will be presented at the National Forum dinner on November 8th, along with the 2010 Geoffrey Marel Medal and National JMO of the Year Award.

p. Stakeholder Engagement

In addition to a strong relationship with Medical Deans at both the executive and secretariat levels, CPMEC is also developing good linkages with Colleges. Relationship with junior doctors through the AMACDT and through CPMEC's ANZJMOC has never been stronger. CPMEC and AIDA have been engaged in ongoing discussions on ways of promoting indigenous health education and supporting indigenous doctors in prevocational years.

CPMEC also continued to advocate actively for prevocational training through submissions to a range of organisations including the Medical Board of Australia and Health Workforce Australia.

Thanks

CPMEC is grateful to the Australian Government's Department of Health and Ageing for its continued support. We are also grateful for the contributions of State and Territory PMCs, particularly for the significant amount of pro bono work provided by PMC office bearers.

Professor Brendan Crotty
Chair, CPMEC
November 3, 2010

Medical Deans
AUSTRALIA AND NEW ZEALAND

Confederation of Postgraduate Medical Education Councils
Consultative Council Meeting, Melbourne, November 7 2010

Report from Medical Deans Australia and New Zealand

Health workforce & health reform

- Graduate going from 2,264 this year to ~ 3,108 in 2014 (internationals: 512→569 in 2015)
- Medical Deans:
  - Campaigning for internships for *all* Australian graduates
  - No further med schools or significant increases in students until sufficient clinical training capacity
- HWA funding announced – but concern remains over pressures on traditional teaching settings
- Education & research in national hospital reforms are critical – KPIs and Board membership

Medical Deans Competencies Project

- Australian Government –funded project
- Led by Prof Alan Carmichael & stakeholder reference group
- Aims to increase clarity (& scope for innovation) in clinical learning
- AMC graduate outcomes a starting point. Building agreement on an 'attributes spectrum' → student learning outcomes for 8 common clinical rotations

Indigenous health projects

- Two new projects funded by DoHA built on work with AIDA
  1. Review of *Indigenous Health Curriculum Framework & Health Futures Project*
  2. National Forum in first half of 2011 to determine strategies for building capacity of Indigenous academic medical leadership
- Collaboration Agreement between Medical Deans and TeOra (Māori Medical Doctors Association) under development

Medical Schools Outcomes Database

- MSOD date proving very useful for medical workforce planning
- 2010 questionnaire administered at all 18 medical schools
- 2010 exit questionnaire collection soon underway
- Seven MSOD-funded research projects

Changes

- Prof Nick Talley replacing Prof Michael Hensley representing the Joint Medical Program of Newcastle and UNE
- Prof Justin Beilby appointed Vice-President of Medical Deans

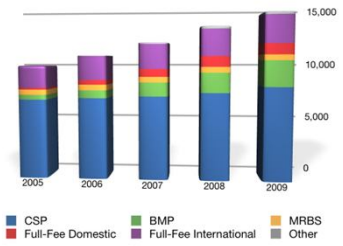
Internships for International Students

Ross Roberts-Thomson
President, Australian Medical Students' Association

Before Internship

- No information given upon entry
- Australia importing doctors
- 19AB Legislation requirements
- Medical school funding

Total Number of Medical Students 2005-2009



Posted by: Heather | 18/08/2010 | 12:18 pm
I am one of the unfortunate international students who has received three rejection letters from IMET, the latest of which I received at 6:30pm on Friday following a long day at my computer continuously pressing the [refresh] button on my browser. I came here to start a life in Australia, knowing that there was a shortage of doctors and being told that getting an internship on completion of my degree would not be an issue. Now, with over $300,000 debt over my head and no job prospects, I can't help but feeling defeated in this whole experience. I've been made to feel like a second-class citizen, having to fight for the scraps left over once local students have had their pick (forget the most prestigious hospitals, I would be lucky to get any offer). I have completed the same course as your local students and will graduate with an honours degree and an impressive resume, but this means nothing because I was not born here. I have paid full tuition, full transport costs (no concession for us lowly internationals), and have contributed to my local community in the past four years, but this means nothing. I am not eligible for citizenship until I can start working, and I cannot work because I cannot complete my medical training without an internship. I am in the process of applying to other countries for internship, but I am very disappointed that the country that accepted me as a student will not accept me as a doctor. Until the internship situation is improved, I am advising other internationals not to come to Australia for school.

- Warn International Students
- Cease Increasing Medical Student Numbers

Internship Allocation

- Different allocation timelines
- Different priority categories
- Different systems used
- Should all international students have to apply to every allocation area?

Easy
Efficient
Equitable

- Process neither costly or onerous
- National preferencing system
- Standardised timings, priority listings, use of priority listings
- Priority given to areas of need
- Neither for or against national system but possibly for a central portal

Questions?

HEALTH WORKFORCE NEW ZEALAND

Brenda Wraight MEdPsych (Hons)
Director

CPMEC Melbourne 7 November 2010

HEALTH WORKFORCE NEW ZEALAND

Established in 2009

to lead the planning and development of NZ's health and disability workforce

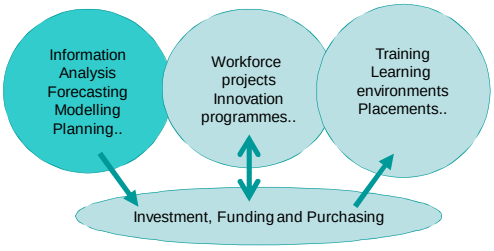
working with whole of health system, whole of education continuum

to ensure a workforce that is sustainable, diversified and fit for purpose.

HEALTH WORKFORCE NEW ZEALAND

Research : Leadership : Partnerships : Communication

Virtual health intelligence group



HEALTH WORKFORCE NEW ZEALAND

HWNZ early priorities *in action*

1. Integration of workforce development functions
2. 3R's: Recruitment, Retention and Repatriation
3. Innovations – demonstration sites
4. Information, data and intelligence
5. Clinical & health leadership

» *In relation to pre-vocational years, these include……..*

HEALTH WORKFORCE NEW ZEALAND

1. Integration of workforce development functions:

Consolidation of workforce development activity into HWNZ

Alignment of planning cycles - tertiary education, HWNZ and District Health Boards

Mitigating current mismatches between labour market needs and the funding/provision of health-related training, and working with

- the Tertiary Education Commission
- Universities NZ

HEALTH WORKFORCE NEW ZEALAND

2. 3R's – Recruitment, Retention & Repatriation

- Medical Student summer studentships in hospital, community and HWNZ settings
- Pastoral Care - Career guidance & mentoring
- Career plans & Tracking scheme
- Regional training hubs
- With MCNZ – changes to provisional registration
- Voluntary Bonding Scheme
- Advanced Trainee Scheme – HWNZ Fellowship

3.Innovations programme

to test the utility of new ways of working that have potential to:

- positively impact on *productivity*
- improve *quality* and outcomes
- *reduce costs* in the long term
- unlock the *potential* of the workforce
- be *sustainable* nationally.

Innovations in relation to pre-vocational training ……..

- GP Training Reform
- Early exposure to Community and General Practice
- Simulated learning environments
- Regional training hubs
- Integrated family health services

4. Information, data and intelligence

- Tracking
- Common data set
- Forecasting and modelling
- Workforce service reviews *
- **Virtual health intelligence unit**

Clinician-Led Workforce Service Reviews

an iterative planning model

Aims: **a** 2020 vision for the health workforce;
informed by changing models of care, IT and service delivery
to inform planning and purchasing (investment and disinvestment)

Includes
anaesthesia, gastroenterology, eye health, diabetes care, mother and babies health, aged care, mental health, rehabilitation, palliative care ……..

Parameters
100% increase in demand and little additional funding
no loss of access or quality, reduces inequalities
regional or national service configurations
multi-disciplinary teams, and the public and private sectors

Timeframe Phase 1 – December 2010

5. NZ Health Leadership Institute.

…..Functions…..

a) Manage an online Health Leadership Portal
b) Coordinate a nationwide regional network of leadership programme providers
c) Partner with third parties to provide Leadership Tools & Support
d) Develop and support an evidence-based Leadership Practice Resource

a) Manage an online Health Leadership Portal which….

- Links to current leadership programmes
- Links to scholarships and existing funding sources
- Provides downloadable/online tools
- Connects leadership networks
- Provides access to leadership content

b) Coordinate a nationwide regional network of leadership programme providers to….

- Develop consistent curricula across regions
- Leveraging expertise across tertiary education organisations
- Link to available TEC funding

c) Partner with third parties to provide Leadership Tools & Support to…

- Modify/license existing competency assessment framework(s) and associated career planning and performance management tools
- Develop/modify/license health system, and quality improvement toolkits (with Health Quality & Safety Commission)
- Provide frameworks, tools and toolkits via membership model to DHB, private sector and other health organisations
- Maintain a NZ database of competency assessments, reporting at sector and DHB/client level re impacts of implemented programmes

d) Develop and support an evidence-based Leadership Practice Resource to

- Access to international best practice/benchmarks
- Support for NZ health leadership research projects
- Development of NZ health leadership research community/network

www.healthworkforce.govt.nz

Expanded Settings for Internship and Prevocational Training -General Practice Education and Training

Prof Simon Willcock
Chair – Board of Directors
General Practice Education & Training Ltd

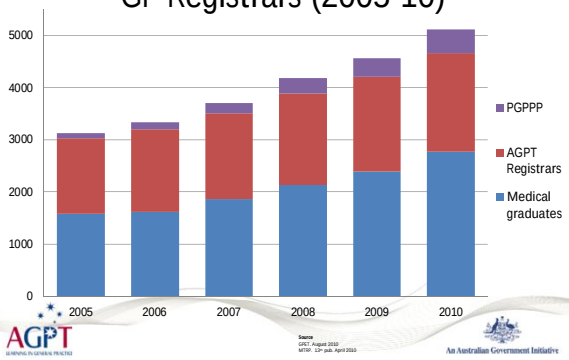
Incorporating the Australian General Practice Training and Prevocational General Practice Placement programs

An Australian Government Initiative

Overview

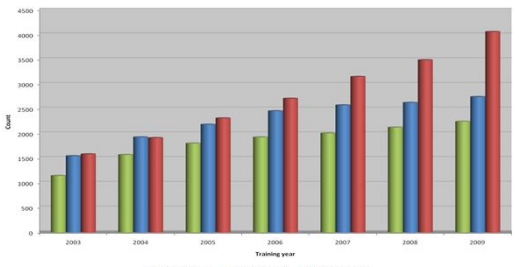
- Medical trainees within primary care
- Current and future training capacity
- Capacity development and resources
- Future challenges and opportunities

Graduate, Junior Doctor and GP Registrars (2005-10)



Training Capacity (2003-2010)

AGPT Registrars and accredited facilities/trainers by training year



Training capacity and educational resources - developments

- Indigenous Health Training
- Vertically Integrated Teaching Practice
- Models of Supervision & Teaching
- National Supervisor Capacity

Training capacity and educational resources

- Future Trainee demand
- Supervisor Professional Development and Teaching
- In-Practice Education & Teaching Resources

Challenges and Opportunities

- Training capacity
- Vertical Integration
- Evolving models of community/general practice e.g. Superclinics, Hub and spoke
- Integration with other training environments e.g. “hospitals”

Challenges and Opportunities

- Supervisor support and practice resources
- Medical education resources and medical educator development
- Alignment and coordination of supervisory incentives
- Developing an education and research culture, with appropriate resources

End

Thank you

CPMEC Advisory Council Meeting

Expanded Settings

7 November 2010, Melbourne

Dr Caitlin O'Mahony
ANZJMOC Chair

Confederation of Postgraduate Medical Education Councils

Summary

- Brief Introduction to ANZJMOC
- Ways to Expand Settings & Standards Required
- Simulation Training
- Clinical Supervision

Australia & NZ JMO Committee (ANZJMOC)

- 2008 National JMO Forum in Tasmania
  - Resolution called upon CPMEC to establish a national committee of JMOs with representation from each state/territory JMO Forum including New Zealand
- 2009 National JMO Forum in Gold Coast
  - Inauguration of ANZJMOC announced
  - CPMEC secretariat support
- 2010 ANZJMOC established
  - Terms of reference developed and meetings held

Roles & Objectives

- Represent Australia and NZ's prevocational doctor's interests in education, training and welfare
- Foster trans-Tasman communication between JMOs, CPMEC and PMCs by improving collaboration on current issues, projects and policy matters
- Steer the annual National JMO Forum
- Monitor and support implementation of resolutions in each jurisdiction

JMO Representation

- Chair, or delegate, is JMO Representative on:
  - PMEF Organising & Scientific Committees
  - CPMEC Consultative Council
  - CPMEC Working Parties (e.g. NRAS, National Intern Allocation Processes, MSOD)
  - MedEd09 Implementation Committee
  - HWA Strategic Study of Postgraduate Medical Training
  - ACF National Steering Group & Working Parties
  - beyondblue DMHP Expert Reference Group

Capacity Expansion

- ↑ medical graduates → ↑ prevocational positions (number & type) → ↑ vocational positions
- BUT currently lack of infrastructure, supervisors, insufficient clinical placement positions…
- THUS potential exists for dilution of Australia's recognised high quality medical training
  - Detrimental effects on patient safety, personal wellbeing, professional advancement
- NOW need innovative ways and adherence to robust standards to provide appropriate infrastructure, clinical experience, education/training, supervision and support for junior doctors

Ways to Expand Settings

- Increasing GP, rural and remote placements
- Alternative training sites - community, private settings
- New rotations within existing facilities
- Redesigning PGY2 positions for PGY1 suitability
- Simulation learning
- Innovative approaches to education and rostering
- Increasing supervisor numbers and training
- Role of interprofessionalism and physician assistants
- Online resources

Expanded Settings Standards

- Robust national prevocational accreditation standards
- The following conditions to be met:
  - Learning objectives & clinical experience consistent with ACF
  - Access to quality supervision & clinical teaching
  - Infrastructure for clinical teaching (e.g. libraries, online resources)
  - Compliance with industrial entitlements
  - Medical indemnity protection

Simulation Training

- Valuable supplement to clinical experience
- Explore use of simulation to support the achievement of ACF capabilities
- Requirement of Internship to complete high fidelity simulation training in Advanced Life Support
- HWA Simulation Learning Environments
  - Ensure access to prevocational doctors
  - JMO & CPMEC involvement in Steering Committees

Clinical Supervision

- All JMOs can access Teaching on the Run
- All registrars can access Professional Development Program for Registrars
- Protected Teaching/Supervision Time
- Interprofessional Learning
- Generic Clinical Supervisor Training Programs
  - HWA Clinical Supervisor Support Program
  - JMO & CPMEC involvement in Steering Committees

Thank You!

Expanding Settings

Dr Michael Bonning
Chair, Australian Medical Association
Council of Doctors-in-Training

CPMEC Advisory Council
Melbourne
November 2010

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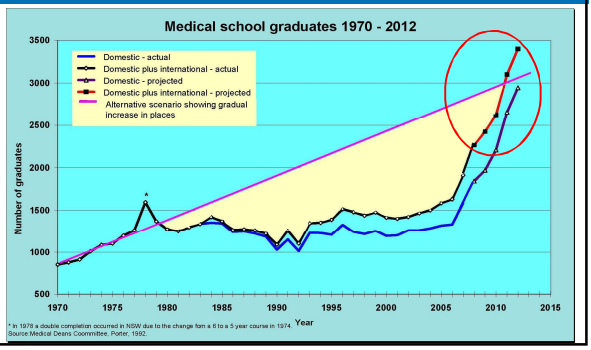
Overview

1. Introduction
2. Internship
3. Prevocational Capacity
4. Pipeline implications
5. Summary

Training Pressure



Internship Capacity

- Capacity growing in line with demand
- System requires planning into the future:
  "an analysis of medical school intakes and graduate numbers through until 2020 and the associated need to increase the available number of medical prevocational and vocational training places to match the growth in medical graduate numbers ..."
- This level of training has strong oversight from CPMEC and defined functions of PMCs
- Co-ordination possibly through a national portal rather than central allocation

Prevocational Capacity

- Less defined post-PGY1
- Obvious and necessary focus on PGY1 so far
- Evidence of rotations being canabalised from previously PGY2-3 level jobs to fulfill PGY1
- May limit preparation for vocational training and increase prevocational time
- PGPPP and expansion of prevocational training into private settings (not just internship)

Pipeline Implications

- Prevocational capacity expansion will have to flow on...
- 2010 ~250 extra 1st year vocational places
- 2015/16 ~>1000 1st year vocational places
- Inappropriate clinical exposure rolling through from prevocational to vocational
- Does prevocational education need to shape a revival of generalism & certain specialties?
- What other workforce implications?

Questions?

Dr Michael Bonning
Chair
Council of Doctors-in-Training
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Australasian Society of Career Medical Officers
www.ascmo.org.au

2010 CPMEC Advisory Council Meeting 7th Nov 2010

Dr Ross White, Vice-President ASCMO

The CMO Workforce

- Australia wide – up to 4,000 providing a service role including long term locums
- Rural, outer urban, and urban locations
- NSW – 1,000 to 2,000 estimated – full time/part time
- ED, HDU/ICU, wards, preanaesthetic clinics, mental health, Obstetrics, community health, D&A, Hospitalists
- Constant medical presence, not on short rotations
- CMOs active in quality assurance/education program/care and discharge planning
- NSW has the Hospital Skills Program for non-specialist doctors not in a specialist training program

ASCMO

- Formed as the Career Medical Officers Association at inaugural meeting on 15 November 1996
- *"It emerged that we shared certain convictions, chiefly that self-determination and professional independence are important issues for the majority of CMOs"*
- *"There must be an alternate, more practical approach to the continuation of medical education across a broad range of skills and interests and we need to take an active part in its evolution"*

2010 ASCMO

- Australian School of Advanced Medicine at Macquarie University has Masters of Medical Practice in Hospital Medical Care
- Other universities planning similar courses
- NSW HSP now statewide
- ASCMO AGM and Educational Event at Macquarie Uni ASAM 19-20 Nov 2010
- Links with RACGP (network of Hospital Medicine) and ACCRM's educational program
- Industrial matters – SA, NSW CMO award, study leave
- Vocational registration and possible College

CMOs and JMOs

- Provide on the job training for JMOs in procedural skills – cannulation, lines, NGT, LP, drains
- Communication and handover training – talking with patients, registrars, consultants, nurses, allied health professionals, cleaners, hospital assistants, ambulance officers
- After hours support for JMOs
- Several Directors of Clinical Training (in NSW DPETs) are CMOs
- In hours support for surgical JMOs when registrars are in theatre/not interested in medical management

CMOs and the expanded JMO Workforce

- Direct supervision of JMOs on evening/night/weekend shifts if overtime ends with JMO wage budget restrictions
- Term descriptions of after-hours terms
- CMOs working in surgical units with JMOs when registrars in theatre
- CMOs could cover wards and ED when JMOs attend compulsory education sessions
- CMOs could replace registrars on leave or at education

Left intentionally blank

Commonwealth Department of Health and Ageing
This paper provides a short overview of recent activities carried out by the Department that may be of interest to the Confederation of Postgraduate Medical Education Councils (CPMEC) and other stakeholders. These are as follows:

Availability of Medical Intern Training places

The Australian Government is aware of increasing pressure to provide medical intern training places for graduates of Australian medical schools.

The Government is working with the states and territories to gain a better understanding at a national level of the work being done to increase medical intern capacity and to allow for improved planning to meet growing demand. The Australian Government recognises the critical importance of a highly trained medical workforce to deliver health outcomes for all Australians, including international students graduating from Australian medical schools.

Information available from the States and Territories indicates that all Australian-trained medical graduates will have access to an internship in 2011. However, the intern placement process will become increasingly competitive from 2012.

Health Workforce Australia (HWA) has agreed to explore options and provide advice to inform and assist jurisdictions to increase the future availability of internships. HWA is expected to report back to the Australian Health Ministers' Advisory Committee (AHMAC) in February 2011.

The Commonwealth and a range of other stakeholders participated in the Australian Medical Association-facilitated Medical Training Summit held on 29 September 2010. The Commonwealth will continue to work with key stakeholders, including the States and Territories through forums such as the Australian Health Ministers Advisory Council (AHMAC), to increase intern place capacity to meet growing demand.

The Commonwealth has already taken action by expanding the Prevocational General Practice Placement Program, a program that provides 12 week placements in General Practice settings for junior doctors, including interns.

Australian General Practice Training (AGPT)Program and PGPPP

The Australian Government has increased the number of training places on both the Prevocational General Practice Placements Program (PGPPP) and the Australian General Practice Training (AGPT) program.

The intake for the AGPT program will rise from 700 in 2010 to: 900 in 2011; 1,000 in 2012; 1,100 in 2013; and 1,200 ongoing from 2014.

The number of placements on the PGPPP will increase from 380 in 2010 to 975 placements from 2012 onwards.

Currently a minimum of 50 per cent of registrars on the AGPT program train in rural or remote locations (defined as Australian Standard Geographical Classification - Remoteness Area (ASGC-RA) 2-5).

The increased number of GP training places will help accommodate the growing number of domestic medical school graduates which is expected to increase from 1,738 in 2008 to approximately 3,108 in 2014. The expansion of general practice training will help increase the overall training capacity for prevocational and vocational trainees in the system, and further support the pathway from undergraduate training arrangements to specialist training in general practice.

Specialist Training Programs (STP)

In 2009/10 the Specialist Training Program (STP) consolidated funding streams for similar initiatives.

The STP has provided support for 365 specialist training positions in settings beyond public teaching hospitals throughout the 2010 academic year- an increase of 10% over 2009.

This includes 20 new pathology training posts and 12 new radiology training positions under the MBS – Diagnostic and Pathology Services – Improving the Quality and Services and Addressing Workforce Shortages measure announced in the 2009-10 Budget.

As announced on 15 March 2010, by 2014 an additional 400 specialist training positions places per annum will be provided. These places will be prioritised towards areas of need, including rural and community places and specialties such as general surgery.

Infrastructure Funding

The National Partnership Agreement (NPA) on Hospitals and Health Workforce Reform included a Commonwealth investment of $175.6 million over four years (2009-10 to 2012-13) in capital infrastructure funding for the expansion of clinical training.

This includes $90 million from 2009-10 – 2012-13 for the Innovative Clinical Teaching and Training Grants (ICTTG) to increase clinical teaching and training capacity outside of tertiary hospitals.

Following a nationally advertised grants round, 35 projects will be funded to provide infrastructure for increased clinical teaching and training across the training continuum.

Rural Health Continuing Education (RHCE) Sub-program

As part of the broader Consolidation of Continuing Education and Training Support initiative announced in the 2009-10 Budget, the Rural Health Continuing Education Sub-Program (RHCE) aims to strengthen Australia's investment in rural training by amalgamating the following programs: the Rural Advanced Specialists Training Scheme (RASTS); the Support Scheme for Rural Specialists (SSRS); and the Rural Health Support Education and Training (RHSET) Program.

RHCE will provide access to continuing professional training and support in rural and remote areas for medical specialists through Stream One Funding and allied health professionals, nurses,

general practitioners and Aboriginal and Torres Strait Islander Health Workers through Stream Two Funding.

The funding administrators are: Stream One Funding - the Committee of Presidents of Medical Colleges (CPMC) and Stream Two – the National Rural Health Alliance (NRHA).

Health Workforce Australia (HWA)

Health Workforce Australia (HWA) has now been established as a statutory authority reporting to the Australian Health Minister's Conference (AHMC) to provide a national, co-ordinated approach to workforce planning.

Although the Department has a funding agreement in place for the operation of HWA, HWA is administratively and functionally separate to the Department.

National Registration and Accreditation (NRAS)

The National Registration and Accreditation Scheme (NRAS) for health professions commenced operations on 1 July 2010, in all States and Territories except Western Australia. Western Australia is expected to join the NRAS from 19 October 2010.

Under the NRAS there is one professional national board setting the standards and policies for the regulation of each of the professions covered, including the medical profession. The national boards are assisted by the Australian Health Practitioner Regulation Agency (AHPRA), which has offices in each State and Territory.

The Scheme covers the following ten health professions: chiropractic, dental care (including dentists, dental hygienists, dental therapists and dental prosthetists), medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology.

From 1 July 2012 an additional four professions will be regulated under the NRAS: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.

The Commonwealth does not have a role in the registration of health professions. Some minor amendments are being made to Commonwealth legislation to support the new Scheme and ensure that access to Medicare remains unchanged.