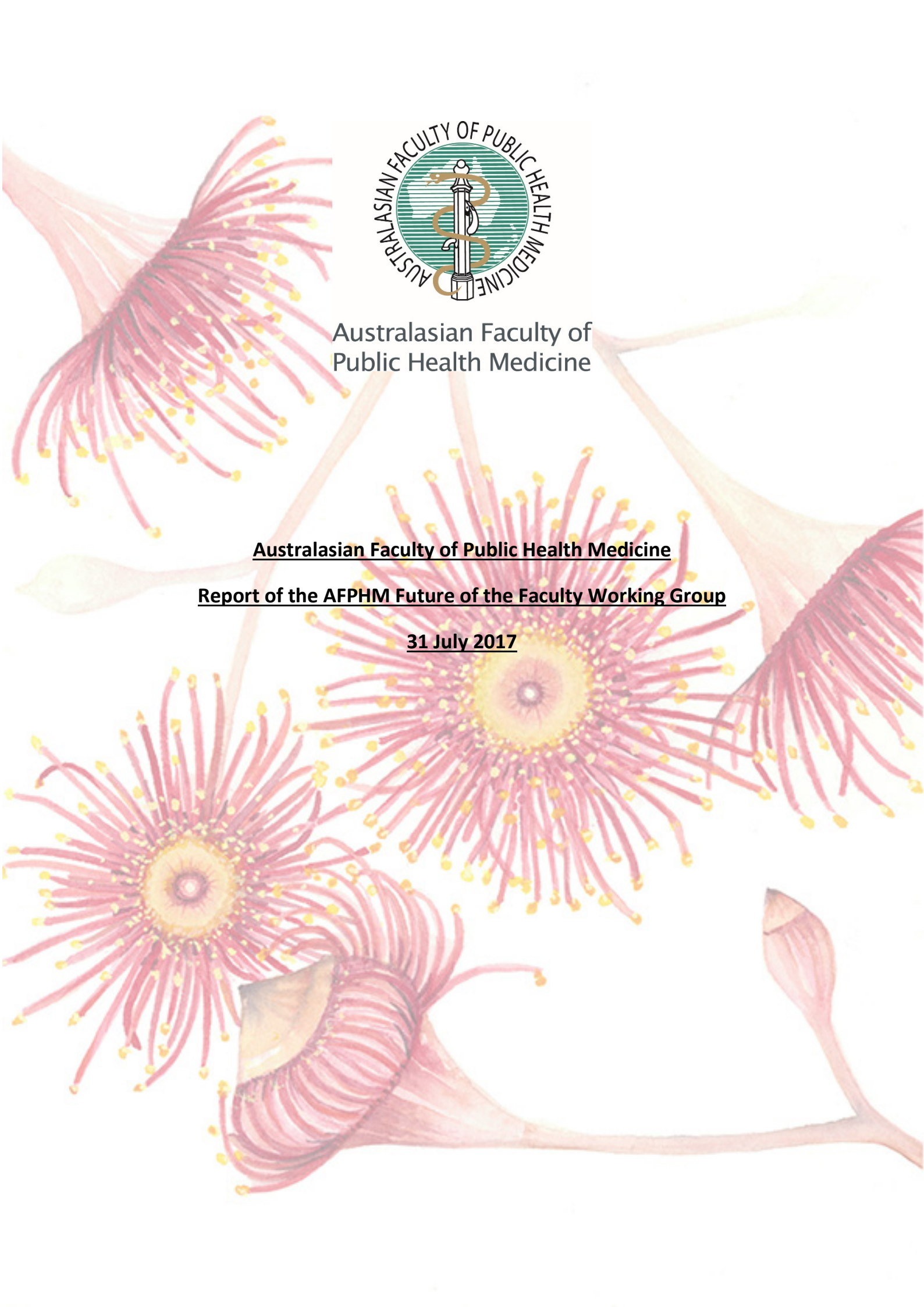

Australasian Faculty of
Public Health Medicine

Australasian Faculty of Public Health Medicine

Report of the AFPHM Future of the Faculty Working Group

31 July 2017

Acknowledgement

The members of the Future of the Faculty Working Group would like to thank sincerely all members of the Faculty, both Fellows and Trainees, who contributed to our consultation process and thereby to the contents of this report. The consultation process was an essential component in reaching the conclusions and recommendations contained herein.

We would also like to thank the College staff who assisted the Working Group in its processes, in particular Kerri Clarke, Faculty Executive Officer.

The botanical drawings of Gum Blossoms and Silver Fern were provided by AFPHM Fellow, Associate Professor Susanne Benjamin.

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Executive Summary and Recommendations

The year 2015 marked 25 years since the formation of the Australasian Faculty of Public Health Medicine (AFPHM) as the first ever faculty of the Royal Australasian College of Physicians (RACP). The Faculty arose from the Australian Association of Community Physicians, formed in the 1980's to provide training in what was then commonly known as Community Medicine. In 1990, the RACP agreed to create a Faculty within its structures to allow the better recognition, training and ongoing professional development of Public Health Medicine specialists in Australia (later Australasia).

Between 1990 and 2009, the Faculty functioned successfully as a semi-autonomous section of the College with, among other autonomous functions, its own Constitution, education program, an oft-used capacity to advocate in the public domain, its own budget and its own Senior Executive Officer who reported directly to the Faculty President and Council. This model had close similarities to the then Faculty of Public Health Medicine of the Royal Colleges of Physicians of the United Kingdom.

In 2009, the College adopted the "One College" model which led, among other changes, to Faculty education and training becoming the responsibility of Education Services of the RACP, limitations on the powers of AFPHM Council, abolition of a separate budget for the Faculty, replacement of the Senior Executive Officer with an Executive Officer with a more limited role, and loss of autonomy across many aspects of Faculty life. Other Faculties and Chapters have experienced similar changes.

The organisational changes that have occurred under the One College model have had serious consequences for the effective functioning of the Faculty particularly with respect to its training program. While the contribution of the expertise of the staff in Education Services is much appreciated, the transfer of all responsibility for Education and Training from the Faculty Office to Education Services has led to the loss of the personalised support previously provided by the Faculty Office to Trainees, and this support has not been sufficiently matched by Education Services. This is a particular problem for AFPHM Trainees as they are frequently isolated and do not have the support from peers and hospital staff available to clinical trainees.

The situation has been exacerbated by the arbitrary withdrawal by the College of funding for support of the Trainees' Learning Contracts, an integral part of the training and assessment for the Faculty, leading to overloading of the Regional Education Co-ordinators. The situation is reaching crisis point and is likely to affect seriously the Faculty's ability to attract Trainees into the AFPHM training program. There is also insufficient recognition on the part of the College that AFPHM training is fundamentally different from clinical training and needs a different approach. Decisions made in forums such as the College Education Committee do not acknowledge these differences.

Other sources of frustration for the Faculty, arising from the One College model, include the loss of any financial autonomy, leading to the requirement to obtain College authorisation (often delayed) for even relatively trivial items of expenditure. The Faculty has contributed substantially to the development of Policy and Advocacy within the College, but there are concerns that there is insufficient autonomy for Faculty spokespeople to advocate on public health issues, both in relation to the public health workforce and more broadly.

These concerns, together with the occasion of the 25th anniversary of the formation of the Faculty, prompted discussion among the Faculty membership, both Fellows and Trainees, about what type of organisation for Public Health Medicine is most appropriate for the next 25 years and, in particular, whether the interests of Public Health Medicine are best served inside or outside the College.

In May 2016, the College Board approved the creation, Terms of Reference and membership of an AFPHM Future of the Faculty Working Group to examine and report on those critical issues. The Terms of Reference of the Working Group were:

1. To determine how the Faculty of Public Health Medicine can enhance its public identity as a recognisable and authoritative body engaged in training and advocacy in Australia and New Zealand;
2. To develop a business case that recommends models for a future professional body of public health medicine; and
3. To articulate the future relationship of the Faculty with the College based on those recommended models.

The Working Group undertook wide consultations and discussions with Faculty members across Australia and New Zealand to determine the best future model for the Faculty. In addressing the issues, the Working Group first developed a vision of the Faculty in 2030. This vision was synthesized into seven "aspirational statements" which are detailed in Section 3. These aspirational statements were used to inform the Working Group's deliberations on possible models.

The Working Group identified four possible organisational models for a future Faculty, some inside and some outside the College. The models are:

Model 1: The status quo, remaining within the RACP under the present arrangements

Model 2: A separate College of Public Health Medicine

Model 3: Addition of a Public Health Specialty Society to the present arrangements

Model 4: More autonomy for the Faculty within the RACP

A detailed assessment of the Models is provided in Section 6 and summarised in tables at Appendix 1. The Appendix also summarises, for Model 4, possible solutions which could be a basis for negotiating more autonomy for the Faculty within the College.

In the view of the Working Group, the status quo is not a viable option for the Faculty. Model 1 cannot achieve the outcome of an enhanced public identity for the Faculty as a recognisable and authoritative body engaged in effective public health training and advocacy in Australia and New Zealand.

It is the firm view of the Working Group that the preferred model is Model 4, a more autonomous Faculty within the RACP. Discussions with the other two Faculties (the Australasian Faculty of Occupational and Environmental Medicine - AFOEM, and the Australasian Faculty of Rehabilitation Medicine - AFRM) have confirmed their interest in being involved in a process with the College to explore this option.

The Working Group wishes to emphasise strongly that its wide consultations confirmed that the membership of the Faculty well understands and appreciates the strength and collegiality that membership of the College brings to the Faculty. This is also seen by members as a two way process, whereby the Faculty brings to our clinical colleagues a Public Health Medicine perspective and expertise particularly in the areas of prevention, policy, advocacy, equity, social justice and research at the population level, and the clinical specialties ground the Faculty in medical practice.

It is the Working Group's considered view that a stronger, more autonomous Faculty within the RACP will lead to a stronger College.

RECOMMENDATIONS

The Future of the Faculty Working Group makes the following recommendations to AFPHM Council:

1. That the Faculty engage with the College in a process of collegial discussion to negotiate a model for more autonomy for the Faculty.
2. That AFOEM and AFRM be formally invited to participate in those discussions and negotiations.
3. That the discussions and negotiations include, but not be Iimited to, achieving the following:
    i. Enhanced ability for the Faculty to advocate in the public domain in relation to issues that are of importance to the Faculty
    ii. Greater capacity for the Faculty to advocate to Governments in relation to the future Public Health Medicine workforce
    iii. An annual budget, under the control of AFPHM Council, to be used for purposes approved by Council, and consistent with the Faculty's role and responsibilities
    iv. Dedicated Senior Executive Officer support
    v. Recognition that the Faculty training and assessment programs must meet specific requirements for population health practice, and consequently require more flexibility in their delivery
    vi. Greater Trainee and Supervisor support, noting the unique aspects of the training program offered by the Faculty
    vii. Capacity for the Faculty to support Public Health Medicine in the Pacific Region, in consort with the New Zealand College of Public Health Medicine
    viii. Capacity for the Faculty to enter into formal agreements with like-minded public health organisations in Australia and internationally.

1. Introduction

The year 2015 marked 25 years since the formation of the Australasian Faculty of Public Health Medicine (AFPHM) as the first ever faculty of the Royal Australasian College of Physicians (RACP). That anniversary, along with discussions about the place of the Faculty within the "One College" model of the RACP, and a lack of visibility of Public Health Medicine among the medical profession and in society more generally, prompted discussion among the Faculty membership, both Fellows and Trainees, about what type of organisation is most appropriate for the next 25 years. The *Future of the Faculty Working Group* was created to examine and report on those critical issues.

The Faculty arose from the Australian Association of Community Physicians, formed in the 1980's to address the concern that Australia remained out of step with the United Kingdom, Canada, the United States and New Zealand in having no recognised training program in what was then commonly known as Community Medicine. In 1990, the RACP agreed to create a Faculty within its structures to allow the better recognition, training and ongoing professional development of Public Health Medicine specialists in Australia (later Australasia). Between 1990 and 2009, the Faculty functioned successfully as a semi-autonomous section of the College with, among other autonomous functions, its own Constitution, education program, an oft-used capacity to advocate in the public domain, its own budget and its own Senior Executive Officer who reported directly to the Faculty President and Council. This model had close similarities to the then Faculty of Public Health Medicine of the Royal Colleges of Physicians of the United Kingdom.

The Faculty recognises that the College structure has changed and grown substantially since that time, with the addition of the Paediatrics and Child Health Division and other Faculties and Chapters. It recognises that its Fellows and Trainees represent only a small proportion of the total College membership (4.2% of Fellows and 1.1% of Trainees[1]), but the skills of this small group make a considerable contribution to the College's strategic goals of shaping the medical workforce strategy and health policy agenda, and supporting research.

In 2009, the College adopted the "One College" model which led, among other changes, to Faculty education and training becoming the responsibility of Education Services of the RACP, limitations on the powers of AFPHM Council, abolition of a separate budget for the Faculty, replacement of the Senior Executive Officer with an Executive Officer with a more limited role, and loss of autonomy across many aspects of Faculty life. Other Faculties and Chapters have experienced similar changes.

In recent times, concerns have been expressed by the membership about the Faculty losing its independent and public identity and, as a consequence, being less able to attract medical students and young doctors to a career in Public Health Medicine. In the long term this has consequences for the future role of medical graduates in public health practice. A high public profile for the Faculty, together with active promotion of the Faculty in medical schools, is needed to demonstrate to interested medical students and young doctors that the practice of Public Health Medicine is a reputable and viable career choice. The question of whether this is best achieved inside or outside the College was a key consideration of the Working Group.

[1] Source – RACP Aptify Database

A recent Workforce Report, undertaken for the Faculty by Human Capital Alliance[2], has highlighted the need for concerted advocacy and action on the part of the Faculty to grow the demand for the Public Health Medicine workforce and to re-orient and strengthen the Public Health Medicine training program to prepare its Fellows for future areas of public health practice. This Report emphasises the need for an active and vibrant Faculty of Public Health Medicine and adds an urgent dimension to future considerations of the role of the Faculty.

With this background, the Working Group embarked on a process of discussion and consultation across the Faculty of Public Health Medicine so as to develop a model for the future Faculty.

[2] Ridoutt, L., Cowles, C., Madden, L., and Stewart, G. (2017) *Planned and Unplanned Futures for the Public Health Physician Workforce in Australia*. Australasian Faculty of Public Health Medicine: Sydney

2. Working Group creation and operation

Creation and role of the Working Group

At its meetings in April and May 2016, and in accordance with the College's "Establishment and Management of Working Groups" By-Law, the College Board approved the creation, Terms of Reference and membership of a Future of the Faculty Working Group for the AFPHM. In doing so, the Board accepted the recommendations of a Board paper, prepared by the then President of AFPHM and College staff, which brought to the Board's attention the concerns of the Faculty membership about the future of the Faculty, as detailed in the Introduction to this Report.

In approving the establishment of the Working Group, the Board requested the inclusion of two non-AFPHM College Fellows in the membership. Members from the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) and the Australasian Faculty of Rehabilitation Medicine (AFRM) were added to the Group. The Working Group's deliberations were greatly enhanced by the presence of these two additional members who brought to the Working Group an independent, external view of the Faculty's possible future, informed by the experiences of their Faculties.

The Terms of Reference of the Working Group can be found at Appendix 2.

The membership of the Working Group can be found at Appendix 3.

The Working Group was established for 12 months from its first meeting (24 August, 2016) and was given the following three key tasks:

1. To determine how the Faculty of Public Health Medicine can enhance its public identity as a recognisable and authoritative body engaged in training and advocacy in Australia and New Zealand;
2. To develop a business case that recommends models for a future professional body of public health medicine; and
3. To articulate the future relationship of the Faculty with the College based on those recommended models.

The remainder of this Report provides details of the Working Group's deliberations and findings in relation to the three key Terms of Reference.

Process of consultation and Report development

The Working Group met on eight occasions, with two face-to-face meetings and six teleconferences. A list of meeting dates can be found at Appendix 4.

Consultations were undertaken with Faculty members in all Australian States and Territories and in New Zealand (Auckland and Wellington). A consultation forum, attended by over 30 Fellows and Trainees, was held at the World Congress on Public Health in Melbourne in April 2017. The World Congress also allowed an opportunity to consult with approximately 50 Trainees, during the Faculty's 2017 Annual Training Days that were held on 1-2 April, 2017. Because of the importance of education, training and ongoing professional development for the Faculty, a specific consultation was held with the Faculty Education Committee (FEC) in March, 2017. Finally, there was consultation at the Faculty's 2017 Strategic Planning Day on 21 July 2017, based on consideration of a draft report from the Working Group. A list of Working Group consultation dates can be found at Appendix 5.

The Working Group took the opportunity of the presence in Australia of three eminent international public health practitioners, Dr Ruth Hussey (former CMO, Wales), Sir Harry Burns (former CMO, Scotland) and Dr Bob Carr (President-elect, American College of Preventive Medicine) to test the processes and point-in-time findings of the Working Group. The key outcome from those meetings was confirmation of the need for the Working Group to develop a future vision for the Faculty, to identify how current processes and structures are inhibiting achievement of that vision, and to recommend a process to rectify the situation.

Consultation with members was a critical and essential process in developing the future Faculty models and recommendations in this Report. Almost 200 members, in a Faculty of approximately 650 Fellows (500 active, 150 retired) and approximately 70 active Trainees[3] in Australia and New Zealand, were consulted.

Consultations consisted of a member of the Working Group, usually along with the President of the Faculty, providing background information about recent governance changes in the College, the creation of the Working Group, its membership and key tasks, and the Working Group's vision for a Faculty in 2030. This was followed by a full and open discussion among those present. As the consultations progressed, additional information was provided about major themes emerging from earlier consultations and possible future organisational models for the Faculty.

All consultations were open, frank and respectful.

Criticisms of the loss of autonomy in the Faculty since "One College" and the consequences for Fellow and Trainee engagement and experience were frequently raised during all consultations. Equally there was recognition of the strength and collegiality that being part of the RACP brings to the Faculty and to Faculty life. This collegiality is seen by members as a two way process, whereby the Faculty brings a Public Health Medicine perspective and expertise particularly in the areas of prevention, policy, advocacy, equity, social justice and research at the population level to our clinical colleagues, and the clinical specialties ground the Faculty in medical practice.

A summary of the key themes that emerged from the consultations can be found in Section 4.

[3] Source – RACP Aptify Database; and advice from Chair of Faculty Education Committee

3. An "Ideal" Faculty in 2030

The first task of the Working Group was to establish a future vision for the Faculty. The Working Group determined that it would develop a vision of what an "ideal" Faculty would look like in 2030.

In doing so, the Working Group recognised that medical Colleges/Faculties are unique organisations that occupy a special place in the professional training and development spectrum. They complement universities and work-place based training and exist only because of the collective action of members of the profession. The idea of a professional group undertaking, pro bono, activities to train young people, to ensure the ongoing competence of members and to provide advice and advocacy in the public domain is striking and precious. Colleges/Faculties are founded on the twin principles of collegiality and subsidiarity, i.e. the collective actions of the membership being determined and undertaken at the most appropriate level of the organisation. This leads to an inevitable conclusion that a future Faculty needs to encourage, support and facilitate the involvement of all members in its activities at all stages of their professional journey.

As noted above, the Working Group began its deliberations by developing a vision for the future Faculty. The final vision was synthesised into seven key aspirational statements:

1. The Faculty is highly recognised for its leadership and advocacy in relation to health, equity and social justice.
2. The Faculty has an active international advocacy and partnership agenda focussed on planetary health.
3. Public Health Medicine has a presence within the medical profession, the health system and society generally.
4. The Faculty's training program is recognised as a model for high quality, financially sustainable, networked training and is a preferred career option for medical students and young doctors.
5. The Faculty has in place an excellent CPD system based on current adult learning principles and processes.
6. The Faculty is governed with flexible, agile and robust processes that allow relevant involvement of all members.
7. There is a productive relationship between the Public Health Medicine professional bodies of Australia and New Zealand, and with the Pacific nations.

Several other aspirational statements were also identified:

1. The value of public health is recognised in a concrete and meaningful way.
2. The Faculty has high level policy influence.
3. There are strong, respected and complementary relationships with the whole medical profession.
4. There is wide recognition of the breadth of opportunities that eventuate through a population approach.
5. The Faculty's Trainees and Fellows have passion and commitment, based on the values of public health.
6. The Faculty has a strong national network (perhaps with virtual offices).
7. The Faculty provides a supportive community for Fellows and Trainees, including through mentoring and free exchange of ideas and information.

The Working Group determined that the seven key aspirational statements would be used to inform the development and assessment of the possible organisational models for a future Faculty. These models are detailed in Section 5.

4. Key themes that emerged from consultations

The key themes that emerged from the consultations were:

The status quo is not sustainable – "something has to change"

There was widespread dissatisfaction with the current governance arrangements under the One College model, in particular the loss of Faculty autonomy and the lack of flexibility and support for Trainees. There were frequent criticisms of bureaucratic barriers in the College that limited responsiveness and flexibility in the Training Program and otherwise. The centralising and inflexible culture of the RACP was raised at many consultations.

There is limited appetite for forming a separate College at this time.

There was a clear recognition of the value and strength the College provides to the Faculty, for example in relation to education/training expertise, AMC accreditation and advocacy. Those consulted recognised the potential disadvantages in forming a separate College of Public Health Medicine, including real financial risks.

There is a strong desire for more autonomy in advocacy, in financial matters and in the conduct of Faculty affairs

The autonomy the Faculty had prior to One College was referred to by many of those consulted. There are many examples from that period of independent and timely public advocacy by the Faculty. The strong public advocacy by the College in recent years in relation to climate change, social determinants of health and refugee health was acknowledged and applauded. However, in the current model such advocacy cannot be relied upon and may be dependent on the interests of the President of the time. There was strong support for regular and ongoing public advocacy for such issues, with the capacity for the Faculty President and other Faculty members to participate actively in public discussions, consistent with College policies.

Autonomy in advocacy relates both to advocacy on issues of public health importance such as those noted above and advocacy for the profession of Public Health Medicine. The latter includes advocacy for training positions with secure funding, and State/Territory networked training programs that provide trainees with a breadth of experiences that optimally prepare them for practice as independent Public Health Medicine practitioners. Increased advocacy by the Faculty on public health issues of national and international significance raises the profile and presence of the Faculty and ultimately works to enhance the reputation and unique contribution of Public Health Physicians to the public's health and to society more generally.

Advocacy in relation to the Public Health Medicine workforce is an urgent issue, but it is difficult to advocate for the special nature of Public Health Medicine training given the College's understandable emphasis on training for the clinical specialties. As noted in the Introduction, the Faculty has recently published a critical analysis of future Public Health Medicine workforce supply and demand[4]. That analysis was recommended by an earlier workforce Report**,** *The Unique Contribution of Public Health*

[4] Ridoutt, L., Cowles, C., Madden, L., and Stewart, G. (2017) *Planned and Unplanned Futures for the Public Health Physician Workforce in Australia*. Australasian Faculty of Public Health Medicine: Sydney

Physicians to the Public Health Workforce[5]. It took almost five years of negotiation and discussion for the funds to be made available for the second Report to be undertaken.

Prior to One College, the conduct of Faculty affairs was controlled by AFPHM Council, with full control over the Faculty budget and support from a Senior Executive Officer. In recent years, the Faculty has been more than ably supported by an Executive Officer, who performs her duties diligently, at the level and scope of the position. However, the higher level strategic support of a Senior Executive Officer has sometimes been missing due to the other commitments of the Faculties Senior Executive Officer, either supporting the other two Faculties or in undertaking projects for the Fellowship Affairs section of the College.

The loss of control over any budget for the Faculty has had adverse effects on the efficient conduct of Faculty business, with the Faculty's priorities not being taken into account and the requirement for authorization of even relatively trivial expenses.

There are many education/training issues to be resolved

Many of those consulted emphasised that, at its core, the Faculty is a training organisation. Difficulties in relation to insufficient support for Trainees and overloading of Regional Education Coordinators were seen as a serious risk to that core function. On the other hand, the value of the expertise provided by Education Services was acknowledged by the Faculty Education Committee and by many of those involved in training as Supervisors or as members of Faculty Assessment and Training committees.

It was noted that although many Fellows of the Faculty maintain some clinical practice in a variety of clinical disciplines including infectious diseases, general practice, Aboriginal health and mental health, Public Health Medicine training is primarily directed towards the health of populations. This is a key difference from the clinical training in the rest of the College which is primarily directed towards the individuals within those populations. It was also noted that there are components of public health in the training of AFOEM and Chapter Trainees.

There has been a lack of recognition by the College that Public Health training is inherently different from clinical training; that, for example, suggestions of a common whole-of-College "First Part" examination cannot apply for the Faculty which has as its first part a Masters of Public Health qualification. As only one Faculty representative (representing all the Faculties) is allowed on the College Education Committee, AFPHM has had difficulties in providing input into decisions about the Education program.

It was noted by several of those consulted that prior to One College, many innovative initiatives were introduced into the Faculty Training Program , such as Learning Contracts and Workplace Reports, uninhibited by the centralised and 'one size fits all' nature of the current arrangements.

The fundamental differences between Public Health Medicine training and training in clinical medicine are not incompatible with One College, but can create challenges, particularly given that they affect only a small minority of College members.

The College has been very active in promoting Specialist Training Program (STP) positions, and this program has been and remains very important for Public Health Medicine training. Nevertheless, these positions represent only a small proportion of RACP STP posts. Consequently, the Program Evaluation Reports for both Trainees and Supervisors focus predominantly on clinical training, and provide little

[5] Ridoutt, L., Madden, L., and Day, S. (July 2010) *The Unique Contribution of Public Health Physicians to the Public Health Workforce.* Australasian Faculty of Public Health Medicine: Sydney

specific feedback to assist the Faculty in assessing the positions or for future advocacy specifically for training positions for Public Health Medicine.

The Faculty has, for some time, attempted to organise a platform to facilitate communication among Faculty Trainees so as to support a "Community of Practice". Faculty Trainees (unlike their clinical counterparts) are often the sole Trainee in their workplace and their workplace may be in a rural or remote location. Contact with peers and peer learning is an essential component of Public Health Medicine training. Past Trainees have organised their own (self-funded) systems as privacy concerns in the College about use of email addresses were a barrier to the College organising such a system.

International partnerships and collaboration are critical for a future Faculty

A very strong theme that emerged from the consultations was the need for the Faculty to be involved in international public health issues such as climate change and planetary health. Partnerships with Public Health Faculties and Colleges around the world were seen as essential in promoting this agenda. There was a desire for such partnerships to be established between the Faculty and relevant international organisations and for this to occur in an expeditious manner.

Greater AFPHM involvement in the Pacific Region to support training and professional development for Public Health Medicine practitioners was seen as an important goal. Several of those consulted went further and stated that it is a responsibility of the Faculty, ideally in partnership with the New Zealand College of Public Health Medicine, to develop this capacity.

A future relationship with the New Zealand College of Public Health Medicine is very important

The separation of Public Health Medicine training in Australia and New Zealand that occurred in 2008 was universally regretted by those consulted. There was a strong desire to create arrangements for better collaboration between the NZ College and the Faculty. Several of those consulted favoured the creation of a single Australasian Public Health Medicine College.

It was noted by several of those consulted, particularly in New Zealand, that the lack of a funded Faculty Training Program in New Zealand will inevitably lead to a decline in New Zealand Fellows such that the Faculty will become non-viable as an Australasian entity. This adds an urgent aspect to consideration of future Faculty models in the New Zealand context.

5. Potential Models for a future Faculty

The Working Group considered, in the first instance, three possible models for the relationship between the Faculty and the RACP. These were:

Model 1: The status quo, remaining within the RACP under the present arrangements

Model 2: A separate College of Public Health Medicine

Model 3: Addition of a Public Health Specialty Society to the present arrangements

The benefits and risks of each of these were assessed by reference to the seven aspirational statements (see Section 3) and using the following functional categories:

- Profile of Public Health Medicine
- Organisational and Financial Issues
- Education and Training
- Policy and Advocacy, and
- Relationships

These benefits and risks are outlined below and summarised in Appendix 1.

After consideration of the issues in each of these areas, a further model was considered, which involved remaining within the RACP, but negotiating more autonomy for the Faculty:

Model 4: More autonomy for the Faculty within the RACP

A detailed assessment of the four models follows.

Model 1: The status quo, remaining within the RACP under the present arrangements

The Working Group considered first the benefits and risks (disadvantages) of the existing arrangements.

Having the AFPHM as a Faculty of the RACP brings considerable benefits to both the Faculty and the College. The profile and status of the Faculty are enhanced by being part of such a large, influential and prestigious organisation. From an organisational point of view the RACP provides access to infrastructure and resources for administration, training and assessment and Australian Medical Council (AMC) accreditation. The access to the support and expertise of staff in Education Services is very important, as is the support for AMC accreditation. In terms of Policy and Advocacy, the RACP has great capacity to influence government policy and debates on health. Through its affiliation with the College, there is also the opportunity for productive collegial relationships with other Divisions, Faculties and Chapters.

Equally, the Faculty brings many benefits to the College: expertise and experience in core public health activities such as prevention, policy, advocacy, equity, social justice and research at the population level; sophisticated understanding of health systems; well-developed policy making and implementation skills; and employment of many Faculty Fellows at senior levels of Government.

Nevertheless, there are several areas in which there is dissatisfaction on the part of Faculty Fellows and Trainees, particularly since the reduction in the autonomy of the Faculty under the One College model.

In training and assessment, while the expertise of Education Services is greatly appreciated, there is insufficient recognition that Public Health training is fundamentally different from clinical training and needs a different approach. Faculty assessments are forced into RACP assessment tools that have been designed for clinical training, and there is lack of recognition that some existing Faculty assessments are equivalent to RACP assessments and could be maintained in their present form. An example is the introduction of the compulsory Research Project which was already covered in existing Faculty requirements for Workplace Reports.

The transfer of all responsibility for education and training from the Faculty Office to Education Services has led to a reduction in the personalized support provided to Trainees by the Faculty Office. The application process for Public Health Medicine training requires more Faculty administrative support than is currently available. This support is required in areas such as the identification of suitable training positions within each jurisdiction, the Recognition of Prior Learning application process, and the MPH competencies' mapping exercise which is particularly complex given the wide range of MPH courses in Australia.

Trainee support is a particular issue for AFPHM Trainees, as they do not have the kinds of support (either staff support, such as Directors of Physician Training, or peer support) available to clinical Trainees working with other Trainees in a hospital setting. An AFPHM Trainee may be the sole Trainee in their workplace and the workplace may be in a rural or remote region. While efforts are being made to strengthen the links between Education Services and the Faculty Offices, more needs to be done to improve the level of support to AFPHM Trainees.

The loss of control over the Faculty Budget since the centralisation of all financial matters with the introduction of One College is of particular concern to the Faculty. This has led to arbitrary decisions such as the removal (without consultation) of funding for a vital support person for the AFPHM Trainees' Learning Contracts, an integral part of the training and assessment for the Faculty[6]. This has led to unreasonable demands on Regional Education Co-ordinators (voluntary) to take over this role. All attempts to have this funding re-instated have been unsuccessful.

Other consequences of the loss of financial control have been the requirement to get College authorisation (often seriously delayed) for even trivial expenses such as Cabcharge vouchers, or the refusal of the College to provide funds for a larger venue to accommodate all Trainees for the National Training Days.

Another area of some concern for the Faculty is in Policy and Advocacy. The Faculty was instrumental in the establishment of a Policy and Advocacy Unit in the RACP. The Faculty has continued to be closely involved in the RACP's policy and advocacy agenda and to tap into RACP capacity to influence government policy and public opinion. However, there are concerns that there is insufficient autonomy for Faculty spokespeople to advocate on public health issues, both national and international. There are inevitable delays in getting approval, which reduces responsiveness to particular issues.

While the relationships with other Divisions, Faculties and Chapters are an important benefit of being part of the College, there appears to be limited capacity for the Faculty, as an entity, to develop formal relationships with external organisations such as the New Zealand College of Public Health Medicine.

[6] The Learning Contract (LC) is a key tool in the AFPHM training program, introduced in 2010. It is an agreed "contract" between the trainee and the workplace Supervisor, covering a specific period of training, to achieve a set of specified outcomes that have been mapped to AFPHM competencies. The Learning Contract Report (LCR) reports on the work which has actually been done during the specified period of training, including the competencies covered and the level of competence achieved. Trainees and Supervisors can monitor training progress and identify competency gaps that need to be addressed during training

Model 2: Separate College of Public Health Medicine

In view of the dissatisfaction with the present arrangements outlined above, the Working Group examined the possibility of forming a separate College of Public Health Medicine. It was agreed that establishment of a separate College would have many advantages, in terms of the credibility and profile of a separate College, the capacity to enhance public health influence and independence, and the ability to create, own and control all training, assessment, accreditation and continuing education. The College of Public Health Medicine would have control over its own organisation and strategic direction and of course its own finances. Furthermore, there would be complete autonomy over policy and advocacy, which could be developed in consort with other public health professionals such as members of the Public Health Association of Australia.

On the other hand, these benefits are offset by the cost of establishing and maintaining the necessary infrastructure, systems and staffing to run the new College. The fees may need to be higher than current RACP fees. The loss of access to RACP IP, training, credentialing, research funding, and loss of access to the financial reserves of the RACP would also be important. The loss of the educational expertise in Education Services and the likely difficulty for a smaller organisation in obtaining AMC accreditation are important issues. It is quite possible that a College of Public Health Medicine would need to contract training and accreditation to the RACP, and this may well lead to reduction in the new College's control of the training program. Another risk is that of fragmentation of the profession, if some Public Health Physicians wished to stay within the RACP. The question of multi-disciplinary membership of a separate College is a complex one, and was outside the remit of the Working Group.

During the deliberations of the Working Group, as well as the consultation process with Fellows and Trainees, it became clear that there was limited appetite for forming a separate College at this time, and so a formal business case for the separate College has not been developed.

Model 3: Adding a Public Health Medicine Specialty Society to the present arrangements

The third option considered was to remain within the RACP under the present arrangements, together with the formation of a Public Health Specialty Society. This is the approach which has been taken by a number of clinical specialties, which have formed Specialty Societies with separate organisational identity, governance and fees. The specialty maintains its present links with the RACP, with the RACP being responsible for education and training and award of Fellowships, while the Specialty Society is responsible for continuing professional education and for advocacy, providing a separate voice for the specialty. In recent times, the relationship between Specialty Societies and the College has been formalised through "Model of Collaboration" agreements. Some Specialty Societies are multi-disciplinary, including other health professionals working in the specialty.

This option was seen to have the potential to enhance the profile of Public Health Medicine, while maintaining the benefits of being part of the RACP. Education and training and therefore accreditation would still be under the auspices of the RACP. There would be more flexibility in the organisation of CPD events, but this would not overcome the Faculty's issues with education and training as outlined earlier. There would be significant costs associated with becoming and operating a Specialty Society including legal costs, insurance, Work Health and Safety, Human Resources, accounts, accommodation, facilities/office equipment, staffing and operating costs. Because of these costs, the fees to join the Specialty Society could be substantial, and it is questionable whether there would be sufficient incentive for Public Health Medicine Fellows to join the Specialty Society. In addition, there may be difficulties in ensuring active involvement of Fellows in both Faculty and Specialty Society. It could be argued that Public Health Medicine already has a multi-disciplinary specialty society in the form of the PHAA (Public Health Association of Australia) and the PHANZ (Public Health Association of New Zealand), of which

many Fellows are, and would wish to remain, members. For all these reasons, the Working Group does not recommend this option.

Model 4: More autonomy for the Faculty within the RACP

There are many benefits and advantages to the Faculty in remaining an integral part of the RACP.

Nevertheless, there are various difficulties, some major and some more minor, which impede the Faculty's effective functioning under the status quo. The Working Group believes that the Faculty's and College's interests are best served if these problems can be addressed by negotiating more autonomy for the Faculty within the RACP. Other Faculties and Chapters have similar issues and a joint approach should be considered.

These problems have already been described above under Model 1, and are summarised under Model 4 in Appendix 1, along with possible solutions which could be a basis for negotiating more autonomy for the Faculty within the College.

Some of the issues that need to be addressed include the issue of more independence in relation to advocacy, and greater recognition of the difference between Public Health Medicine training and clinical training, leading to more flexibility in assessment requirements to meet the needs of Public Health Medicine training.

A very significant issue for the Faculty is the completely centralised financial control under the present arrangements, which means that the Faculty has very limited capacity to influence the use of RACP resources, even for Faculty purposes, and cannot make decisions about even relatively trivial expenses. Provision of a discretionary budget for the Faculty, allowing for more financial independence, is a very important point for negotiation. Obviously, the Faculty would be accountable for the expenditure, in accordance with RACP policies and procedures.

In considering possible solutions, the Faculty also needs to consider steps which it could take (with or without money), and not only the changes to be requested of the College.

6. The Way Forward

The Working Group was required to address three Terms of Reference. It summarises its findings in relation to those Terms of Reference as follows:

1. **Determine how the Faculty of Public Health Medicine can enhance its public identity as a recognisable and authoritative body engaged in training and advocacy in Australia and New Zealand**

Enhancement of the public identity of AFPHM requires an organisational model that allows the Faculty to be, and be seen to be, actively engaged in society, the health system and the medical profession. The outcome of such active engagement has been described in detail earlier in this Report i.e. a vibrant Public Health Medicine organisation with an active and committed membership that attracts high quality medical students and young doctors to its ranks, that provides excellent training and opportunities for lifelong learning, that is respected as an important component of the medical profession, and that is actively involved and influential in advocacy about and improvement in health and wider government policy.

The Working Group has formed the view that this enhanced public identity can be achieved either inside or outside the College, and by different organisational models. The Working Group is convinced, however, based on its own discussions and wide consultation with Faculty members, that the best model is that of more autonomy for the Faculty within the College.

2. **Develop a business case that recommends models for a future professional body of public health medicine**

Given the findings in relation to Term of Reference 1, it was not necessary for the Working Group to develop a business case for any model.

3. **Articulate the future relationship of the Faculty with the College based on those recommended models**

The following Recommendations provide some initial detail about what "more autonomy for the Faculty" would mean. The process of discussion and negotiation recommended will allow full exploration of how the proposed model might be developed and implemented.

Note that AFPHM has had initial discussions with the other two Faculties and they have expressed their interest in being involved in this discussion process. In due course, if a suitable model is developed, it could also be used for the College Chapters.

RECOMMENDATIONS

The Future of the Faculty Working Group makes the following recommendations to AFPHM Council:

1. That the Faculty engage with the College in a process of collegial discussion to negotiate a model for more autonomy for the Faculty.

2. That AFOEM and AFRM be formally invited to participate in those discussions and negotiations.

3. That the discussions and negotiations include, but not be Iimited to, achieving the following:

    i. Enhanced ability for the Faculty to advocate in the public domain in relation to issues that are of importance to the Faculty

    ii. Greater capacity for the Faculty to advocate to Governments in relation to the future Public Health Medicine workforce

    iii. An annual budget, under the control of AFPHM Council, to be used for purposes approved by Council, and consistent with the Faculty's role and responsibilities

    iv. Dedicated Senior Executive Officer support

    v. Recognition that the Faculty training and assessment programs must meet specific requirements for population health practice, and consequently require more flexibility in their delivery

    vi. Greater Trainee and Supervisor support, noting the unique aspects of the training program offered by the Faculty

    vii. Capacity for the Faculty to support Public Health Medicine in the Pacific Region, in consort with the New Zealand College of Public Health Medicine

    viii. Capacity for the Faculty to enter into formal agreements with like-minded public health organisations in Australia and internationally.

Appendix 1: Future Models: Advantages/Disadvantages

MODEL 1: AFPHM IN RACP (STATUS QUO)

Benefits/Advantages	Risks/Disadvantages
Profile of Public Health Medicine Faculty is part of a large, influential and prestigious organisation (domestic and international recognition)	Separate identity of Faculty is not always obvious
Education and Training Access to support and expertise of Education Services, especially in organisation of assessments; support for AMC accreditation Access to RACP CPD recording system	Lack of recognition by RACP of the unique nature of PH training. ('One College' – one size fits all) Limited capacity for different approaches to training, e.g. difficulty in funding support for Learning Contracts Insufficient autonomy over assessments; some mandatory requirements appropriate for clinical settings – their conversion to PH settings is clumsy and difficult to implement. Very limited direct contact between Faculty personnel and Trainees reduces Faculty's support of Trainees
Organisational/Financial Solidity of assets and sufficient resources to undertake core business Reduced costs - economies of scale RACP provides access to infrastructure and resources for administration, geographical network, IP, training and assessment, AMC accreditation, CPD	Limited capacity to influence the use of RACP resources No financial independence; no capacity to make financial decisions on even relatively trivial matters
Policy and Advocacy Can tap into RACP capacity to influence health and government policy Association with RACP may increase profile of Public Health with key stakeholders	Insufficient autonomy for Faculty to advocate on workforce issues, education and training, and public health issues – national and international Requiring RACP approval for advocacy activities reduces responsiveness. RACP more conservative approach on some issues
Relationships Opportunity for good relationships with other Divisions, Faculties and Chapters; collegiality and fellowship	Reduced opportunities for developing formal relationships with external/international public health organisations

MODEL 2: SEPARATE COLLEGE OF PUBLIC HEALTH MEDICINE

Benefits/Advantages	Risks/Disadvantages
Profile of Public Health Medicine Credibility of a College name Enhance public health identity, influence and independence	Loss of the benefits of being part of the RACP (see under status quo)
Education and Training Ability to create, own and control all training, assessment, accreditation and continuing education	Difficulty for a smaller organisation of obtaining AMC and MCNZ accreditation Loss of educational expertise of Educational Services in RACP Cost of providing support services for training and assessment Would need to advocate separately with the Commonwealth for training places (*risk or benefit?)* Cost of running CPD
Organisational/Financial Responsible for own organisation and strategic directions Capacity to include multi-disciplinary members Opens possibility of collaboration/union with NZCPHM	Cost of establishing and maintaining the necessary infrastructure, systems and staffing to run the new College Fees may need to be higher than current RACP fees Loss of access to RACP IP, training, credentialling, CPD, research, Foundation funding, systems and staffing. Loss of access to the financial reserves of the RACP Risk of fragmentation of profession if some Public Health Physicians wish to stay within the RACP
Policy and Advocacy Complete autonomy over policy and advocacy Policy and advocacy can be developed in consort with other health professionals e.g. with PHAA	Separate advocacy voice, but lacks the strength, size and reputation of RACP
Relationships Opportunities to develop formal relationships with other relevant organisations such as NZCPHM, UKFPH, American College of Preventive Medicine	

MODEL 3: PUBLIC HEALTH MEDICINE SPECIALTY SOCIETY

Benefits/Advantages	Risks/Disadvantages
Profile of Public Health Medicine Enhances profile of PHM while keeping benefits of being part of RACP	
Education and Training Education/training and therefore accreditation would still be under the auspices of RACP	More flexibility with organisation of CPD events, but would not overcome education/training issues
Organisational/Financial Affiliated with RACP – acceptable option to the College Aligned with the aims and objectives of the RACP and the Faculty	Dual fees for Fellows and Trainees, triple for PHAA members Combined fee likely to be greater than fees paid today – additional cost a disincentive to membership Significant costs associated with becoming and operating a Specialty Society including legal, insurance, OHS, HR, accounts, office systems, accommodation and staffing Need for continuous and ongoing membership recruitment, support, media, website, database, ASMs, communications etc. Difficulty in ensuring active involvement of Fellows in both Faculty and Specialty Society – limited volunteering If non-physician membership, would be competing directly with PHAA
Policy and Advocacy Not bound by RACP policy and advocacy issues and processes. Policy and advocacy can be developed in consort with other public health organisations, particularly with PHAA	Risk that government and other stakeholders would not recognise and interface with Specialty Society, preferring to interact solely with RACP
Relationships Existing relationships with other Divisions, Faculties and Chapters of RACP maintained. Potential for formal relationships between Specialty Society and others with common interests	

MODEL 4: MORE AUTONOMY FOR FACULTY WITHIN RACP

This model would involve the Faculty continuing to be an integral part of the RACP, but with increased autonomy to be negotiated. This table summarises some of the problems for the Faculty under the current arrangements and some possible solutions which might be up for negotiation.

Benefits/Advantages of staying within RACP	Problems/Difficulties	Possible solutions
Profile of Public Health Medicine Faculty would continue to be part of a large, influential and prestigious organisation (domestic and international recognition)	Separate identity of Faculty not always obvious	Ability of the President to speak publicly on issues which are relevant to Public Health Medicine as, for example, President of PCH does
Education and Training Weight of influence of RACP in advocating for training positions Continued access to support and expertise of Education Services, especially in organisation of assessments; support for AMC accreditation Access to RACP CPD recording system	Insufficient autonomy to advocate for PHM on workforce issues, training positions (STP) Insufficient flexibility with respect to assessments. Faculty assessments forced into RACP assessment tools, mainly designed for clinical training Lack of acknowledgment of value of existing assessments (Workplace Reports) Loss of personalised Faculty support for PHM Trainees due to transfer of education responsibilities to Education Services Limited capacity for a different approach to training: Loss of funding to support Learning Contracts	Negotiate for more flexibility in planning assessments more suited to PHM training. Recognition that some existing Faculty assessments are equivalent to RACP assessments and can be maintained in their present form (Workplace Reports) Strengthen links between Faculty Office and Education Services Additional support for Trainees in Faculty Office Introduction of platform for trainee networking (e.g. Moodle)

MODEL 4 (continued)		
Benefits/Advantages of staying within RACP	**Problems/Difficulties**	**Possible solutions**
Organisational/Financial Solidity of assets and sufficient resources to undertake core business Infrastructure and resources for administration, training and assessment; AMC accreditation; CPD Economies of scale	Insufficient financial autonomy Long delays in response to requests for funds Faculty unable to authorise payment of even trivial expenses	Greater delegation of financial responsibility and decision-making to Faculty More autonomy for Faculty in funding decisions re staff appointments. SEO level appointment for Faculty Office Discretionary budget for Faculty
Policy and Advocacy Can tap into RACP capacity to influence health and government policy Association with RACP may increase profile of Public Health with key stakeholders	Insufficient autonomy for Faculty to advocate on public health issues – national and international Requiring RACP approval for advocacy activities reduces responsiveness. RACP more conservative approach on some issues Competing with other disciplines and members to have public health issues prioritised and approved	Negotiate more independence in policy and advocacy Closer links with PHAA/PHANZ for advocacy purposes; need to explore this with PHAA/PHANZ
Relationships Opportunity for good relationships with other Divisions, Faculties and Chapters within RACP Opportunity for collegiality and fellowship.	Limited capacity for Faculty to form relationships with other organisations as a separate entity	Negotiate formal relationships with other entities e.g. NZCPHM, the UK Faculty of Public Health and the American College of Preventive Medicine

Appendix 2: Terms of Reference

The Royal Australasian College of Physicians

Terms of Reference

AFPHM 'Future of the Faculty' Working Group

TERMS OF REFERENCE FOR THE ESTABLISHMENT AND MAINTENANCE OF WORKING GROUP OF THE BOARD TO BE KNOWN AS AFPHM FUTURE OF THE FACULTY WORKING GROUP

CONTENTS

1 INTRODUCTION AND PURPOSE

1.1 The Board, has established the AFPHM 'Future of the Faculty' Working Group (the *Working Group*) to operate in accordance with these Terms of Reference (*The 'Future of the Faculty' Working Group Terms of Reference*)

1.2 The Board has approved AFPHMs establishment of the Working Group to:

1.2.1 determine how the Faculty of Public Health Medicine can enhance its public identity as a recognisable and authoritative body engaged in training and advocacy in Australia and New Zealand;

1.2.2 develop a business case that recommends models for a future professional body of public health medicine; and

1.2.3 articulate the future relationship of the Faculty with the College based on those recommended models.

1.3 The Working Group must not:

1.3.1 enter into contractual relationships; or

1.3.2 represent or imply in any way that the Working Group is a body independent of the College.

2 COMPOSITION OF THE WORKING GROUP

2.1 The Working Group shall comprise:

2.1.1 two AFPHM Council members

2.1.2 up to four Fellows and trainees with an interest in the 'Future of the Faculty' and

2.1.3 two members from the Divisions and other Faculties.

2.2 The Working Group will appoint its own Chair in addition to the members identified in clause 2.1.

3 DURATION OF WORKING GROUP

3.1 The Working Group is created for an initial period of 12 months.

3.2 The initial period of 12 months will start from the date of the first meeting of the Working Group.

3.3 The Board may extend the period of operation of the Working Group but unless extended by the Board the Working Group will become dormant 12 months after the date of the first meeting of the Working Group.

3.4 If period of operation of the Working Group is extended by the Board**,** the Working Group will become dormant at the expiry of the first or any subsequent extension period.

4 MEETINGS

4.1 The Working Group will hold the following meetings:

4.1.1 The Working Group shall meet face to face up to twice per calendar year.

4.1.2 The Working Group shall meet by teleconference a further two times per calendar year.

4.1.3 The Working Group will hold Member forums in all jurisdictions.

5 REPORTING

5.1 The Working Group will report to AFPHM Council and also provide a six month update and a final report to the College Board within one month of the completion of its term.

6 DEFINITIONS

"Board"	means the Board of Directors of the College
"College"	means the Royal Australasian College of Physicians (ACN 000 039 047), an incorporated body limited by guarantee.
"Constitution"	means the Constitution of the College as amended from time to time.
"Fellow"	has the same meaning as set out in the College's Constitution
"Trainee"	has the same meaning as set out in the College's Constitution**.**

Approved by the Board on Friday 13th May 2016.

Terms of Reference History as from 13 May 2016		
Commencement of Terms of Reference		
These Terms of Reference were approved by the Board on 13 May 2016 and commenced on that date.		
Subsequent amendments to Terms of Reference		
Item	**Amendment**	**Commenced**

Appendix 3: Membership of Working Group

Following consideration and approval by the College Board, the membership of the Future of the Faculty Working Group included a Chair, two members of AFPHM Council, four members of AFPHM and one member each from the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) and the Australasian Faculty of Rehabilitation Medicine (AFRM). Dr Greg Stewart was appointed interim Chair by AFPHM Council for the first meeting of the Working Group. His appointment as ongoing Chair was confirmed at the first meeting. The AFPHM Council members were appointed by AFPHM Council, the AFPHM nominated members were appointed following an open Expression of Interest process. The AFOEM and AFRM members were appointed by those Faculties. The final membership is listed below. This membership ensured an appropriate geographic and gender balance, and included members from among the Faculty's Trainees, its emerging leadership and its established Fellows:

Dr Greg Stewart – Chair

Dr Judy Straton – AFPHM nominated member

Dr Sue Morey – AFPHM nominated member

Dr Robert Hall - AFPHM nominated member

Dr Kushani Marshall – AFPHM nominated member (Trainee)

Dr Andrew Old – AFPHM Council member

Dr Simon Crouch – AFPHM Council member

Dr Helen McArdle – AFOEM nominated member

Dr Greg Bowring – AFRM nominated member

Appendix 4: Dates of Working Group meetings

24 August 2016	Face-to-face (Macquarie Street, Sydney)
26 October 2016	Teleconference
16 December 2016	Teleconference
3 February 2017	Face-to-face (Macquarie Street, Sydney)
20 March 2017	Teleconference
19 April 2017	Teleconference
21 June 2017	Teleconference
25 July 2017	Teleconference

Appendix 5: Dates of Working Group consultations

1 September 2016	Queensland Regional consultation
12 October 2016	Victorian Regional consultation
21-22 November 2016	New Zealand consultations (Auckland & Wellington)
30 November 2016	Dr Ruth Hussey (former CMO Wales) Sir Harry Burns (former CMO Scotland)
15 December 2016	NSW Regional consultation
15 December 2016	Dr Bob Carr (President-elect, American College of Preventative Medicine)
14 March 2017	South Australian Regional consultation
24 March 2017	Faculty Education Committee (FEC)
2 April 2017	Faculty Trainees (at Faculty Training Days meeting)
3 April 2017	Open consultation (at World Congress of Population Health 2017 conference)
1 May 2017	Western Australia Regional consultation
21 June 2017	ACT Regional consultation
23 June 2017	Northern Territory Regional consultation (teleconference)
11 July 2017	Tasmanian Regional consultation (teleconference/email)
21 July 2017	AFPHM Strategic Planning Day