A Better Culture

# Leadership Diversity Working Group Report

*Consultation Draft December 2024*

## Acknowledgements

A Better Culture acknowledges and pays our respects to the Traditional Owners of the lands across Australia and extend our gratitude for their contributions to health and healing. Our offices are located on the lands of the Wurundjeri people of the Kulin nation and we pay our respects to their Elders and ancestors past and present and acknowledge that Sovereignty was never ceded.

The project was commissioned by the Commonwealth Department of Health and Aged Care in December 2022 to address high rates of bullying, discrimination, harassment and racism (BDHR) experienced by doctors, and is hosted by the Royal Australasian College of Medical Administrators (RACMA).

The Advisory Board and the project team extend sincere gratitude to the Reference Group members for their tremendous efforts and valuable contributions since the project's inception. We also acknowledge the invaluable support provided by various associations and organisations, including the specialist medical colleges, which have played a pivotal role in supporting the project and its working groups.

## Disclaimer

These reports are consultation drafts developed based on discussions among the working group members. While the members represent diverse stakeholders within the healthcare sector, the reports, recommendations, and any views expressed are solely those of the working group and do not reflect the official positions or views of their respective organisations. The contents of these reports should not be attributed to any organisation.

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# 1.0 Executive Summary

# 1.1 Executive Summary

Leadership Diversity is one of the five working groups of A Better Culture. This report examines the gender and race differentials in the results of the Medical Training Survey and proposes a rationale for leadership diversity as one part of a comprehensive program of work to address this.

A Better Culture prioritised two aspects of diversity (gender and race) for the purposes of driving focused discussions. That is not to say that these are the only two areas of diversity where attention is needed. For example, disability is an area that is little examined in medicine, and when it has been, it has been through a lens of regulatory “fitness to practice”, creating stigma and fear.

Neurodivergence, remoteness, rurality, age, gender diversity or non-conformity and sexuality are all elements of diversity where systems would benefit from developing a habit of applying an intersectional diversity lens to power structures and decision-making. In summary, intersectional diversity is the approach that is ultimately needed.

Although intersectional diversity is now considered to be the most powerful tool for driving reform, there is almost no examination of its application in healthcare — even from the patient’s perspective. It is an area of knowledge and practice that would benefit the entire nation, if all healthcare workers could come to understand how the intersection of race, gender, sexuality, poverty, language, disability, and other areas of disprivilege impact the day-to-day experience of both our colleagues and patients.

The further up the healthcare leadership ladder one looks in Australia (and around the world), the less the workforce reflects the gender and ethnic composition of the broader workforce, or even the communities they serve. Australia has only recently begun to address gender (the first ever national gender equality strategy was published in 2024). Discussion about race is largely absent — perhaps because of the paucity of racial diversity in powerful leadership roles in Australia. This has implications for safety of care and also impedes healthcare organisations’ ability to have all members of the workforce reach their full potential.

Healthcare does not operate in a social vacuum — many of the issues described in this paper are societal issues. The need to address them in the healthcare context is urgent because of the impact on patient care.

We propose data collection, transparent reporting, targeted interventions, middle-management development, a re-thinking of leadership models, and a re-imagining of diversity as an asset to be leveraged rather than an issue to be managed.

## 1.2 Recommendations

**Develop a national program for measurement and reporting of workforce and leadership diversity in health care. This should**:

- Establish a baseline by transparently reporting current workforce composition and, at a minimum, examining gender and race (and preferably other aspects of diversity) to measure the diversity of different health profession cadres, along with how well that diversity is reflected across the range of seniority and pay scales.
- Collect and report (as currently happens in other countries) data about the diversity of applicant pools for both jobs and training programs, and report on the related diversity of successful applicants.
- Amend the Medical Training Survey so that data on race, neurodiversity, disability and more is collected, allowing correlation of these factors with training experience.

**Using the data above (preferably, but if not available, using other methods), identify fall-off points in the career development pipeline and provide targeted interventions to diverse employees and enhance their access to career opportunities**.

**Address institutionalised drivers of inequality:**

- Collect and examine data on diversity for temporary promotions or special projects that are filled without a formal recruitment process.
- Ensure that there is transparency of methods for funding allocation to leadership activities, so that unconscious bias against diverse leaders does not set them up for failure through inequitable resourcing.
- Examine (for each professional grouping) gender and race pay gaps at each appointment level, and identify and address drivers of any gaps (e.g. overtime, inequitable or biased criteria for promotion)

**Develop specific strategies to reach and motivate mid-level managers who are critical to creating a truly inclusive leadership pipeline. While top leadership commitment is key, the day-to-day experience of emerging leaders is shaped by their immediate supervisors.**

### Re-examine and challenge existing stereotypes of leadership

- Implement strengths-based leadership development assessment and training. Current models of deficit-based assessments cause diverse groups to be under-valued by metrics that reinforce historical stereotypes of leadership.
- Develop systems and structures to learn from First Nations ways of knowing and being for the benefit of all patient and staff populations.
- Implement a variety of leadership models, learning from other cultures, including shared leadership

### Implement programs that elevate the perception of diversity as an asset, rather than an issue to be managed.

- Promote and celebrate multilingualism.
- Leverage the global sourcing of healthcare staff — continuously invite and respect proposals for improvements and economies that are effective and proven in other countries, being sure to guard against unconscious preference for anglosphere or European initiatives.
- Create systems and structures that allow employees of diverse perspectives to be valued and be seen to be valued. Encourage diversity of thought.

# 2.0 Introduction

## 2.1 Project Overview

For many years, the Medical Board of Australia has collected data about work and career plans to support workforce planning. In 2019, for the first time, a comprehensive medical training survey was offered and completed by almost 10,000 doctors-in-training.

That first survey demonstrated high levels of bullying, harassment, and discrimination, with 22% of trainees reporting that they had experienced these behaviours directed at them during the previous 12 months. Unfortunately, in the 2024 survey, with over 24,000 respondents, that number is still 22%, with racism included as a separate item in the 2022 and 2023 surveys, and sexual harassment added in 2024.

Across an entire generation of doctors-in-training, and despite significant efforts at addressing the issues, the results remain stubborn. The 2024 data is different in breakdown from 2019, with improvement in the reported proportion of cases that involve other healthcare staff, but an increase across that period of those experiencing behaviours at the hands of patients/family members or carer. Senior doctors, peers, nursing and allied health staff are, to varying degrees, also identified as sources of adverse behaviours.

Recognising the unacceptable nature of these persistent findings, in October 2022, the Commonwealth Department of Health and Aged Care reached an agreement with the Royal Australasian College of Medical Administrators to repurpose some unspent funds from RACMA's Specialist Training Program to establish A Better Culture.

The repurposing was to address the year-on-year findings of bullying, harassment, racism and discrimination that were reported through the Medical Board of Australia's Medical Training Survey. The original badging of the project was The Culture of Medicine.

A Better Culture has been established with independent governance over content, with its own advisory board, reference groups, and working groups. RACMA relinquished this function to deliver a program where all Colleges could participate as equal partners and share ownership of these important reforms.

## 2.2 Working Group Overview

The key deliverables for the Leadership Diversity Working Group were as follows (note: the purpose and scope from the Terms of Reference are provided in Appendix A):

- Identify good practice in leadership diversity in the healthcare sector or other industries.
- Identify gaps in existing healthcare leadership programs with respect to attracting and promoting diversity in leadership and identify opportunities for additional areas for improvement.
- Identify sites of good practice (jurisdiction, state health, primary health networks) and enablers and barriers to participation, particularly those that may be unique to doctors, and especially women and culturally diverse populations.
- Make recommendations for consideration by employers and colleges as a whole-of-system recommendation.
- Develop a model set of competencies for 21st century healthcare leaders that cultivate diverse leadership participation.

This report delivers on the first four items of the Terms of Reference. The fifth is not specifically addressed because the work has been done by experts such as the Diversity Council of Australia, and the Curriculum Design Working Group overlaps with this work.

*Table 1 List of Working Group Members*

| Name | Role |
|---|---|
| Dr Nisha Khot (Co-Chair) | Vice President, RANZCOG and Clinical Director of Obstetrics and Gynaecology at Peninsula Health |
| Dr Nicole Higgins (Co-Chair) | Immediate Past President, RACGP and general physician |
| Dr Jillann Farmer (Lead Author) | CEO, A Better Culture |
| Dr Ajith Thampi | Emergency physician |
| Dr Andrew Frazer | General physician |
| Dr Catherine Olweny | Paediatric anaesthetist |

| | |
|---|---|
| Mr Cory Paulson | Manager of First Nations Health, Royal Flying Doctor Service (Southeastern Section) |
| Dr Edward Wims | Psychiatrist |
| Ms Jan Elsner | Psychologist |
| Dr Kerrie Meades | Ophthalmologist |
| Dr Lea Merone | Director of Medical Services, Yarrabah Hospital |
| Dr Navin Rudolph | General/Breast/Endocrine surgeon |
| Dr Sarah Whitelaw | Emergency physician |

## 2.3 The Logic of the Deliverables

### What is Leadership Diversity?

Leadership diversity refers to the inclusion of individuals from various genders, ethnicities, ages, and abilities in leadership positions, reflecting the rich variety of experiences and perspectives within the broader community and workforce (Hesselberg et al., 2023). This diversity goes beyond mere representation; it encompasses the integration of diverse experiences, perspectives, and skills within leadership roles.

### Why is Leadership Diversity a Focus for A Better Culture?

A Better Culture was initiated to address the findings (year on year, without improvement) of the Medical Training Survey, demonstrating unacceptably high levels of bullying, harassment, racism, and discrimination.

While the overall aggregated data fit a pattern that is slightly worse than other sectors, disaggregation by gender and by Aboriginal and Torres Strait Islander identity shows that the healthcare sector is rife with privilege, and with gendered and racialised experiences of work.

Leadership in health care across the globe, with Australia being no exception, does not reflect the communities that healthcare entities serve, and does not even reflect the workforce that delivers services. This has been documented by organisations such as the World Health Organization (2021) and Women in Global Health (2023), and extensively in the peer reviewed literature (Teede et al., 2019; Bismark et al., 2015; Haines & McKeown, 2023; Mucheru et al., 2024; Hassen et al., 2021; Holmes et al., 2024).

Examination of trainee attitudes to reporting adverse behaviours in the Medical Training Survey data shows that trainees usually do not report, with the two most commonly cited reasons for non-reporting being a lack of faith that anything will be done and a fear of repercussions (Medical Board of Australia, 2024 (Q4.8.5)).

During consultations in the early part of A Better Culture's work, repeated reference to leadership and perceptions of leaders' alignment with trainees arose, with frustration expressed about some training programs' archaic attitudes to female trainees, flexible work arrangements, parenting, non-traditional career paths, and perception of racial and gender bias in selection processes. Leadership diversity was identified as one of the project pillars that may address these issues.

There has been limited examination in the literature of the linkage between diversity of leadership and the experience of diverse workforce members. One study did demonstrate that board gender and ethnic diversity reduces the likelihood of discrimination lawsuits, particularly when there is a critical mass of diverse directors (Abebe & Dadanlar, 2021). Companies with greater gender and ethnic diversity in leadership show better financial

performance (Richard et al., 2021). Racial minorities are more satisfied with their job and organisation when there are higher levels of racial and ethnic diversity in managerial positions (Choi, 2013). These statistics help dispel the myth that “diversity” is an existential risk to organisational success — on the contrary, it is becoming recognised as a key ingredient for success.

Although limited, these studies do support the contention that improving leadership diversity in health care is likely to have a positive impact on workforce experiences of bullying, harassment, discrimination, and racism, and a positive effect on the performance of healthcare systems.

Rebalancing the sheet to better reflect both society and workforce is not “reverse racism” or “reverse discrimination”. However, for those accustomed to privilege, its loss can be perceived as discrimination.

Promotion of leadership diversity must be done with sensitivity and respect to avoid a model for inclusion becoming a model where some (e.g. white men) feel excluded or attacked. Such sensitivity is necessary not only because it is the right thing to do, but because it militates against the risk of backlash that inevitably occurs when certain groups feel attacked. Those considerations notwithstanding, progress requires the uncomfortable acknowledgement that certain groups in medicine have enjoyed privilege, and that historically “merit”-based appointment has not necessarily resulted in the appointment of the most meritorious candidates. The exclusion of women and people of colour is a simple historical fact that continues to reverberate through the profession today.

This exclusion does not only affect marginalised groups who are directly targeted, but also the wider cohort, as even the most traditionally privileged groups benefit from improvements in workplace culture and a strengthening of workers’ rights. For example, men now benefit from flexible work arrangements and parental leave, once only the domain of women. The closing of the gender pay gap improves pay for all workers, regardless of their gender (Lagarde & Ostry, 2018). Efforts to paint diversity and inclusion as an attack distracts from the real issues and prevents broadening of horizons for what healthy workplaces, and society at large, could achieve.

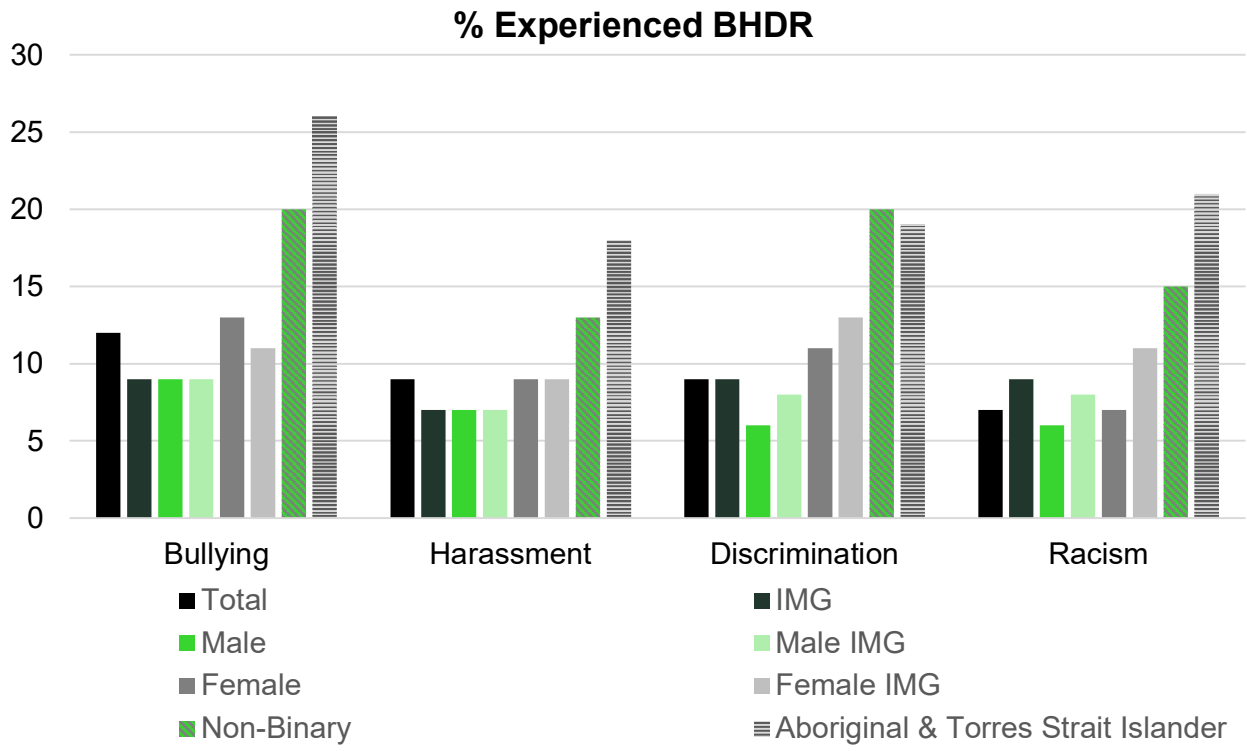
Sexual harassment was not included in the original project brief because the data was not collected in the Medical Training Survey. The first published data on sexual harassment was released in December 2024, with three per cent of trainees overall (4% female, 1% male and 7% non-binary) reporting that they have experienced sexual harassment in the prior 12 months. This further bolsters the case for leadership diversity.

# 3.0
# The Challenge

## 3.1 The Medical Training Survey Data

The Medical Board of Australia collects data about the experience of early-career doctors each year during the registration renewal period. Each year, survey respondents have reported high levels of bullying, harassment, racism and discrimination.

The Medical Training Survey is a national, annual, profession-wide survey of all doctors in training in Australia. The Medical Training Survey is run by the Medical Board of Australia and AHPRA.




In their responses to the 2024 survey, doctors in training reported that in the previous 12 months:

- One in three doctors in training (35%) reported they had either experienced and/or witnessed bullying, harassment, sexual harassment, discrimination, and/or racism in their workplace, with 22% experiencing it themselves, and 29% witnessing this behaviour.
- Women and non-binary individuals were more likely to experience adverse behaviours than men (men 17%, women 25%, and non-binary 41%).
- This was even higher for Aboriginal and/or Torres Strait Islander trainees, with 54 per cent reporting they had experienced bullying, harassment, discrimination, and/or racism.

- For payment of un-rostered overtime there was a gender difference as well, with 17 per cent of non-binary trainees nationally reporting that they are never paid for unrostered overtime, compared with 11 per cent of male and 12 per cent of female trainees.
- International medical graduates reported higher rates of discrimination and racism than the general cohort. It should be noted that many such graduates' ethnicity is white Caucasian, so their experiences of racism may be limited. Unfortunately, the survey does not ask about race, so it is highly likely that culturally and racially marginalised doctors experience levels of racism and discrimination that are higher than demonstrated in the reported data.

## 3.2 Current State of Leadership Diversity in Healthcare

While there are efforts to promote leadership diversity in healthcare, significant gaps remain.

Women constitute a significant majority across 15 different health professions in Australia: approximately 73%. In 2021 workforce data, medicine and chiropractic were the only two professions where women were in minority, at 44.4 per cent and 41.3 per cent respectively (Anderson et al., 2023). By 2023, the percentage of women in medicine had increased to 45.37 per cent, a trend of increase that will continue based on the gender ratios of provisional registrants and medical school enrolments, where women now outnumber men, and have done for the past five years (Department of Health and Aged Care, 2024a).

Despite the high representation in the workforce, women occupy only about 30 per cent of senior leadership roles (Lalloo, 2023; Cohn et al., 2021; Hempenstall et al., 2019)

Since the federal position of Chief Medical Officer (CMO) was established in 1983, there has been one female incumbent: Dr Judith Whitworth, 1997–1999. In the 41-year history of CMOs, there have been just three years of female leadership. There have been none this century, and there has never been a CMO from a culturally or racially marginalised group (Department of Health and Aged Care, 2020, 2024b; National Library of Australia, 2014).

Efforts to improve gender diversity have led to some progress, with initiatives like gender equity policies and mentorship programs (Georgousakis & Vassallo, 2023). However, true solutions lie at higher levels than individual practitioners. One intensive implementation science research program is currently working to identify and support implementation of practices and approaches that elevate women into leadership roles in health care. It has identified that leadership intent and organisational readiness are two of the three top factors that support women into leadership roles (Mousa et al., 2022)

The healthcare workforce in Australia is ethnically diverse, with significant representation from various cultural backgrounds, including Asian, Middle Eastern, and African communities. Racial and ethnic minorities, including First Nations Australians, face significant underrepresentation in leadership, a situation not unique to Australia and extensively examined in North America (e.g. Ruzycki et al., 2021) and the UK (e.g. Kline, 2014).

Despite the healthcare workforce being ethnically diverse and relatively inclusive at entry and mid-level positions, this diversity does not extend into the upper echelons of management and decision-making roles. A brief internet review of publicly available information on leadership teams in the Commonwealth Department of Health and Aged Care and the jurisdictions yielded the following information (disclaimer: this data is only as accurate as the departmental websites and cannot identify all aspects of diversity).

- Commonwealth: three of nine members of the department top tier (secretary and deputy secretaries) are women, with no discernible culturally or racially marginalised representation, including the deputy secretary responsible for First Nations health.
- Jurisdictions: Several not publicly available or not up to date.

a. NSW, VIC, TAS, SA: three of nine, three of nine, three of eight and six of eight female top team members respectively.
b. ACT Health: 100 per cent female team members.
c. QLD, NT and WA: not publicly available

- No visibly culturally and/or racially marginalised (CARM) team members in these jurisdictions except designated First Nations positions and one chief psychiatrist in Tasmania.

A review of the Commonwealth department's website on diversity and inclusion reveals action plans for LGBTQI and First Nations, and networks for gender and culturally and linguistically diverse populations (Australian Government Department of Health, 2018). There is no specific publicly identifiable departmental initiative to address gender or racial equity in leadership, but these may be internal documents.

# 4.0 Leadership Diversity Initiatives in Healthcare and Beyond

# 4.1 Australian Initiatives and Programs

## Advancing Women in Healthcare Leadership (AWHL)

This extensive program is an implementation research project hosted by Monash University that aims to address that deficit in implementation noted above and has multiple implementation projects underway.

The five key research areas are:

### Organisational Change Management

Working with organisations to design and implement evidence-based interventions to advance women in healthcare leadership.

### Nursing Leadership

Understanding and overcoming barriers unique to the career advancement of women in nursing.

### Collective Action with Member Organisations

Identifying the role of member organisations in gender equity and women's career advancement in healthcare and working together for change

### Leadership Development

Determining the essential components required in leadership development programs for women in healthcare.

### Exploring Intersectionality

Exploring the intersection of other identities, such as race and ethnicity, because women's experiences are not the same and we need to look beyond gender alone (Monash University et al., n.d.)

AWHL has also recently published a proposed data framework to support monitor and report on the status and progress of gender equity.

## Diversity Council Australia

Diversity Council Australia (DCA) is an independent, not-for-profit body focusing on diversity and inclusion (D&I) in Australian workplaces. Their work promotes intersectional density, from perspectives of Aboriginal and Torres Strait Islander peoples, age, culture and religion,

disability and accessibility, family and domestic violence, gender, LGBTIQ+, mental health, parental leave, and race (Diversity Council Australia, n.d.).

Focus areas most relevant to A Better Culture's work are:

### The RISE Project

Realise, Inspire, Support, Energise: aiming to help culturally and racially marginalised women progress to leadership positions (DCA, 2023a).

### CARM (Culturally and Racially Marginalised) Women in Leadership

A framework for intersectional organisational action (DCA, 2023b).

### The Inclusion@Work Index

A survey that maps the state of inclusion in the Australia workforce (DCA, 2024).

### Counting Culture

A standardised approach for defining, measuring, and reporting on workforce cultural diversity (DCA, 2021).

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## Australian Medical Association

In October 2023, the Australian Medical Association (AMA) published an equity, inclusion, and diversity plan, which has the following key focus areas:

### Work Participation

Advocate for pathways to support work participation and career progression for international medical graduates, doctors with disability, and doctors returning to work after a prolonged absence.

### Cultural Safety

Collaborate to support Aboriginal and Torres Strait Islander doctors and doctors from culturally and linguistically diverse backgrounds to work and train in culturally safe environments, free from racism (AMA, 2023a).

### Equity and Inclusion

Support equity and diversity in our representative structures across the AMA and create a culture where members feel they belong.

Even prior to this overarching plan, the AMA has long monitored gender equity in its representation committees and has a target of 40/40/20: 40 per cent male, 40 per cent

female, and 20 per cent unspecified. That target was met in the AMA Federal Council for the first time in 2022 (AMA, 2023b).

## Working for Women: A Strategy for Gender Equality

*Working for Women: A Strategy for Gender Equality* was published by the Department of the Prime Minister and Cabinet on International Women's Day 2024.

It sets out a path to make progress over the next 10 years, with a focus on five priority areas:

- gender-based violence,
- unpaid and paid care,
- economic equality and security,
- health,
- leadership, representation, and decision-making.

These priority areas all have relevance to healthcare leadership.

Of most relevance to this paper is the priority area of leadership, representation and decision-making. Unfortunately, the Commonwealth strategy is silent on addressing the gross underrepresentation of women within public sector leadership, other than to focus on entry pathways to parliament and boards. The low-hanging fruit of examining public sector (in particular, health sector) appointment processes to identify and address the factors that result in repeated appointments of men from fields that include many (or even a majority of) highly qualified women remains unaddressed.

## The Victorian Commission for Gender Equality

The 2021 baseline audit published by the Victorian Commission for Gender Equality in the Public Sector found that career development opportunities are inequitably distributed, favouring men. Despite making up 66 per cent of the workforce across all defined entities, women comprised only 62 per cent of those staff accessing career development training opportunities and only 58 per cent of those awarded internal secondments. While men comprised 34 per cent of the overall workforce, they made up 38 per cent of those staff accessing career development training opportunities and 42 per cent of those staff awarded internal secondments.

This data concords with feedback from our consultation processes, where practitioners expressed a strong view that there is plenty of training available, but that opportunities to apply that training, and demonstrate leadership capacity are elusive for women and culturally and racially marginalised groups. This has a feed-forward effect, where, having been unable to achieve visibility, women are then overlooked for "shoulder-tap" opportunities that can lead to even greater visibility and promotion.

## PwC Gender Initiative

Notwithstanding recent probity concerns relating to its consulting business in Australia, PwC provides a case study of hard key performance indicators (KPIs) to drive change.

As an early adopter of the UN He For She program (PricewaterhouseCoopers, n.d), PwC has developed several gender-focused KPIs, including women partner admissions, proportionality of promotions, women experienced hires, the representation of women in succession planning and women leading priority accounts (PricewaterhouseCoopers, 2024). This type of leadership intent and leadership accountability for executing on that intent is sorely missing from health care in Australia and, despite PWCs recent scandals, this work on equity and diversity remains an excellent example of the difference that leadership action (as opposed to leadership lip-service) can make.

## Women in Leadership: Lessons from Australian Companies Leading the Way

A collaboration between The Business Council of Australia, McKinsey and Company and the Workplace Gender Equality Agency, *Women in Leadership: Lessons from Australian Companies Leading the Way* (2018), provides an evidence-based recipe for dismantling barriers to women's participation at senior levels and a correlation between representation of women in senior roles and the practice of normalising flexible work.

The report proposes a 10-step recipe for getting more women into leadership.

1. Build a strong case for change.
2. Role-model a commitment to diversity, including with business partners.
3. Redesign roles and work to enable flexible work and normalise uptake across levels and genders.
4. Actively sponsor rising women.
5. Set a clear diversity aspiration, backed up by accountability.
6. Support talent through life transitions.
7. Ensure the infrastructure is in place to support a more inclusive and flexible workplace.
8. Challenge traditional views of merit in recruitment and evaluation.
9. Invest in frontline leader capabilities to drive cultural change.
10. Develop rising women and ensure experience in key roles.

## Miwatj Health Leadership Model

The leadership approach of the Miwatj Health Service in Arnhem Land has been examined as a successful case study of First Nations leadership development in Australia (Harfield et al., 2021).

Notably, the model recruits and develops local Yolngu people to leadership roles in the health service. The model has not yet been adapted or adopted to foster First Nations leaders in organisations where First Nations staff are a minority group.

# 4.2 International Initiatives and Programs

The journey to racial equity has advanced further in the UK, US, and Canada than in Australia, with far more open dialogue about race and its impact on society. As a result, there are myriad organisations promoting racial equity and providing tools, resources and support to achieve this goal. Some examples are below:

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## National Health Service (NHS) Workforce Race Equality Standard

This standard was initiated in the UK in 2015, with mandatory reporting by trusts of core indicators. There is publication of employment outcomes, highlighting that white job applicants are more likely to be shortlisted and appointed but, since reporting started, the trend is encouraging (NHS, 2024). There is no equivalent national standard for health care in Australia.

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## Royal College of Obstetricians and Gynaecologists (RCOG)

RCOG has an established race equity project and published its first report in 2024. The project is tackling admission, career progression and other manifestations of discrimination that racially and culturally diverse doctors face in the UK (RCOG, 2024).

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## Equity in the Center

Equity in the Center is a US-based consultancy seeking to drive diversity, equity, and inclusion in the non-profit and philanthropy sectors (Equity in the Center, 2024). It has a range of products that are targeted at racial equity in workplaces. These include a guide, *Awake to Woke at Work*, and a tool to measure progress, *Race Equity Pulse Check*.

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## Race to Lead

Race to Lead has published a toolkit and a report examining barriers to leadership for racially diverse populations titled *Race to Lead Revisited* (Building Movement Project, 2024).

In that latter document, the following stark comment is made:

*“To take effective action to meaningfully address racial inequities, existing DEI efforts on race and racism must move beyond awareness and discussion to enact tangible changes in organizational policies and practices. To do that, organizational leadership must examine the formal and informal rules guiding their workplaces that maintain white dominance.”*

Such initiatives seem unthinkable in Australia, where we have yet to fully accept the degree to which race impacts the experience of people in the workplace.

# 5.0 Opportunities for Improvement and Barriers to Action

# 5.1 Opportunities for Improvement

Having examined all of the above, the most striking gaps in Australian healthcare are as follows:

## Clear Leadership Commitment

There is no public discourse on the benefits of increased leadership diversity, the shocking lack of it in health care, or a clear commitment to address it. This absence is particularly striking when considering the array of initiatives and commitments in the private sector to address racial and gender equity.

## Open Discussion About Race and Racism

Australia remains hesitant to even discuss this, as highlighted in the recently published Anti-Racism Framework (Australian Human Rights Commission, 2024). It is striking that in 2022, the first report on cultural diversity on boards was published (Women on Boards, 2022).

## Measurement and Transparency

Courageous transparency and KPIs are demonstrably associated with progress. There is no transparent diversity reporting (such as the NHS does) of recruitment applicant fields vs. shortlisted vs. appointed in Australian healthcare, or even in the Australian Public Service,

## Recognition of the Particular Struggles of Women in Medicine

Recognition of the need for gender equity approaches from healthcare employers to explicitly include the experiences of female doctors. Healthcare workforce gender equity can be dominated by progress in the female-dominated professions of nursing and allied health, masking the glacial pace of change in medicine.

## Strengths-Based Development Programs

Recognition and elevation of the strengths that diverse groups and leaders bring to health care. Emphasising the strengths drawn from diverse backgrounds and cultures to enrich both staff and patient experience, including leadership models from diverse cultures.

## Valuing Multilingualism

Despite having a very diverse population to be served and having a diverse workforce to serve them, little emphasis or reward is given for multilingualism. Valuing second and third language skills is not a common experience in Australian workplaces

## 5.2 Barriers to Action

To fully comprehend the challenges facing advancing diversity in healthcare leadership, the broader Australian context bears examination. Australian workplaces as a whole are a very long way from gender equity in leadership, with just 22 per cent of CEOs being women and a "seniority drop-off" eroding the percentage of women appointed at every level of the advancement ladder (Workplace Gender Equality Agency, 2023). Similarly, board chairs across all industries are most likely to be men, even in the health and care sector, where 74 per cent of the workforce are women (Department of Health and Aged Care, 2024a).

The overall Australian Gender Equity Scorecard for 2023 shows that we are far from a gender-equitable society.

One in three (34.8 per cent) Australians hold a negative bias about women's ability to participate fully economically, politically or in education.

Attitudes towards gender equality are not more progressive in younger Australians (aged 16–24 years old); their rejection of gender inequality is the same as the average Australian — unsurprisingly, because they are shaped by the environment in which they grow up. 43 per cent of young women and only 20 per cent of young men (aged 16–24 years old) reject attitudes that underpin gender inequality. Gendered expectations of social roles, assumptions, and pressures for what roles women should undertake outside of work result in a disproportionate burden of caring being placed on women for both care of children and care of elders (Department of the Prime Minister and Cabinet, 2023). Women in health care are not exempt from this.

Another barrier to solutions is "health care exceptionalism" — when solutions and progress that are working in other sectors are deemed unsuitable for healthcare environments for no clear reason other than a sense that health care is different. Notably, where research is happening, there is little evidence emerging that unique solutions are needed for health care. It seems mainly to be a case of health care recognising and systematically responding to what is already known.

Women and diverse entrepreneurs are demonstrated to struggle to attract venture capital, with clear bias towards funding initiatives from men, and predominantly white men (Al-Saleh, 2023; Lambert-Patel, 2023). Investors prefer pitches from male entrepreneurs compared to pitches made by female entrepreneurs, even when the content of the pitch is the same (Brooks et al., 2014). Anecdotally, this phenomenon presents some challenges as well in health care, where initiatives led by men may be, by the same inherent bias, more likely to get a profile, achieve funding, and be perceived as successful. This, in turn, perpetuates perceptions that there is an actual capability gap when, in fact, it is another expression of structural bias and barriers.

# 6.0 Lessons Learned and Next Steps

# 6.1 Lessons Learned

## More Data is Needed

A Better Culture was established primarily to address workplace bullying, harassment, racism and discrimination. These issues matter because they are recognised as psychosocial hazards that have a direct impact on the health and safety of healthcare workers, and on the clinical safety of healthcare delivered by those workers (Katz et al., 2019). Even so, given the lack of deliberate and focused investment on improving healthcare workplaces, it seems that more data is needed to quantify the benefits of a healthy workforce and help to make the business case.

## Hierarchies and Power Structures

Hierarchies and power structures were identified as drivers of inequality and adverse workplace behaviours. Doctors in training are at the bottom of the medical hierarchy and are socialised from very early in their training to behave with deference to seniors. Many medical students would hesitate to use the first name of a consultant who was teaching them — it is “Dr X, Professor Y” (although they may be more willing to un-title women instructors) and while this may be perhaps not unusual at undergraduate levels, to see the deference continue past graduation and into the workplace is startling. That deference can turn to obeisance when career advancement decisions are made within that same reporting line, and makes it much, much harder for doctors in training to challenge or report adverse behaviour.

## Occupational Health and Safety, not “Wellness”

Adoption of an occupational health lens to disability would normalise and support workforce participation by objectively evaluating job demands and capability, rather than allowing blanket assumptions about what a person with a disability may be able to do. This would also benefit practitioners who acquire disability either through illness or accident and may support retention of precious workforce. Overall, health care in Australia could learn lessons from international agencies and health systems who more systematically engage occupational health services for their staff.

## Remote and Rural Practitioners

Remoteness and rurality merit particular consideration as an aspect of diversity, because it is not usually considered as such. However, consultation feedback was that leadership pathways can be particularly elusive for rural and remote practitioners. The intersecting impacts of geography, race and potentially gender illustrate why an intersectional approach is ultimately needed.

## Artificial Intelligence (AI) Impacts and Amplification of Non-Diversity

As AI and technology increase their healthcare footprint, consideration for the impact on diversity warrants consideration. Technology fields are already male dominated, and women and racial minorities in tech face many of the same barriers as diverse groups in health care. It will be important in coming years to ensure that the merging of technology and healthcare cultures does not amplify the challenges that both face in advancing equity.

# 6.2 Next Steps

## The Consultation Round

This consultation draft is open for feedback until 15 February 2025. Feedback will inform the final report which will be presented to key stakeholders in March 2025.

# 7.0 Minority Report

# 7.1 Minority Report

This report was formulated in a consensus model. Working group members had extensive input and were provided with an opportunity for final signoff.

One working group member did not feel that their views were adequately represented in the report and was invited to prepare a minority report to be included in the consultation draft.

That member's report is reproduced verbatim below.

*Because I disagreed with the draft report of the [Leadership Diversity Working Group] I was asked to write a report, encapsulating my position.*

*I joined [the project and Leadership Diversity Working Group] in order to change the culture of bullying, harassment and sexism in medicine. I did not expect to change the Australian culture for another culture based on race and/or sex.*

*Leadership diversity (gender, race, disability and age) should emphasise the principles of equality and meritocracy as foundational elements for achieving a truly diverse leadership landscape.*

*Points I would like to make;*

a. *We should promote all people trained in medicine so that the practice of medicine offers the practice of excellence not mediocrity for the sake of political correctness.*

b. *Compulsory multilingualism and embracing medical systems not based on science seems inadvisable*

c. *Privilege is a relative thing and varies throughout cultures. However, most people support the concept of giving their children and grandchildren a better future even to the point of moving countries. Parents sacrificing their income in order to educate their families should not be regarded as privileged*

d. *Public service positions are often related to longevity in the service, which may explain why it will take some time for this to change. Private practice must be based on profit and requires a different skill set*

e. *Hierarchies and a military like culture has been in medicine as medicine is unique and the margin of error has to be very small. Like pilots and captains on ships, the person in charge has to be responsible for critical decisions. Replacing one race and /or sex with another will not necessarily replace a bullying and harassing leadership style in these situations*

*1. **Gender diversity**.*

*Gender diversity requires organisations to create an environment where all genders have equal access to leadership roles. To ensure that meritocracy prevails, organisations must*

*implement unbiased recruitment and evaluation processes. This includes using standardised assessment tools and diverse hiring panels to minimise biases that may disadvantage any gender. By focusing on skills, qualifications and potential rather than gender, organisations can cultivate a more equitable leadership structure.*

*2.**Racial diversity**.*

*Organisations must provide equal opportunities for individuals from all racial backgrounds. Leadership roles however should be filled based on performance and qualifications rather than racial backgrounds. Establishing clear, objective criteria for advancement can help ensure that all employees have the opportunity to succeed based on their merits.*

*3.**Disability inclusion**.*

*Leadership opportunities should be based on capability rather than an individuals disability status. By focusing on the strengths and skills of individuals with disabilities, organisations can benefit from a more diverse talent pool that enhances overall performance.*

*4.**Age diversity**.*

*Leadership selection should prioritise experience and skills rather than age. By embracing a blend of ages in leadership roles, organisations can leverage the strengths of both younger and older leaders, fostering an environment rich in diverse perspectives. Intergenerational mentorship programs that encourage knowledge sharing and collaboration between younger and older employees may help.*

***Conclusion**;*

*Everybody should have equal chance at a position regardless of their background, race and/or sex.*

*Some recent attitudes in our society have had a political agenda, being antiprogressive and divisive in nature and destructive to progress in this cost-of-living crisis. These attitudes can create angry, disenfranchised groups which in a democracy and a majority group can be a very powerful force. Let us not repeat history. We must recognise the contribution of meritocracy, honoring our heroes. Not all white males are the same and not all people want to be leaders.*

*By emphasising equality and meritocracy, organisations can create environments where every individual has the opportunity to thrive based on their abilities and contributions. This approach not only leads to better organisational outcomes but also fosters a more inclusive society.*

Dr Kerry Meade
FRANZCO

Disclaimer: As with the main report, this minority report does not represent the views of any organisation and has not been endorsed. The views expressed are those of the author.

# 8.0 Appendices

# 8.1 Appendix A: Leadership Diversity Working Group Terms of Reference

## Purpose and Scope

These terms of reference establish the Leadership Diversity Working Group for A Better Culture. The Working Group is established to support the advisory board via provision of content expertise and focused initiatives to support greater diversity for advancement into leadership roles. The working group will be comprised of experts in equity, diversity, inclusion and belonging, complemented with lived experience from reference group members.

For consideration:

- Outputs should not duplicate programs but should map gaps and identify opportunities for additional areas for improvement.

The Leadership Diversity Working Group will be time limited and in place until the end of 2024, at which time it will be disbanded. Oversight will be provided by the advisory board until the project closes and hands over management of workplace culture reform to "business as usual" elements of various entities.

## Responsibilities

The primary responsibility of the working group is to:

- identify good practice in leadership diversity in the healthcare sector or other industries.
- identify gaps in existing healthcare leadership programs with respect to attracting and promoting diversity in leadership and identify opportunities for additional areas for improvement.
- identify sites of good practice (jurisdiction, state health, primary health networks) and enablers and barriers to participation, particularly those that may be unique to doctors, and especially women and culturally diverse populations.
- make recommendations for consideration by employers and colleges as a whole-of-system recommendation.
- develop a model set of competencies for 21st century healthcare leaders for cultivating diverse leadership participation.

# 8.2 Appendix B: Definitions

*Table 2: List of Terms and Definitions*

| Term | Definition |
|---|---|
| **Diversity** | **Diversity** is about what makes each of us unique and includes our backgrounds, personality, life experiences, beliefs — all the things that make us who we are It is also about recognising, respecting and valuing differences based on ethnicity, gender, age, race, religion, disability, and sexual orientation. It can also include an infinite range of individual unique characteristics and experiences, such as communication style, career path, life experience, educational background, geographic location, income level, marital status, parental status, and other variables that influence personal perspectives. (Victorian Government, 2023). |
| **Equality** | **Equality** is recognising that, as human beings, we all have the same value (Australian Human Rights Commission, 2023). This means we all have the same rights, and we should all receive the same level of respect and have the same access to opportunities. |
| **Equity** | **Equity** is about everyone achieving equal outcomes. We all have the same value and deserve a good life, but we all start from a different place, due to a variety of political, historical, and social factors outcomes (Australian Human Rights Commission, 2023). This context means sometimes we need to be treated differently to achieve the same level of opportunity. |
| **Inclusion** | **Inclusion** occurs when people feel valued and respected regardless of their personal characteristics or circumstances (Victorian Government, 2023). They should have the opportunity to fulfil their individual and combined potential according to their talents and perspectives, have access to opportunities and resources, and bring their full selves to their jobs. |
| **Belonging** | Similar to inclusion, **belonging** is the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group (Cornell University, 2023). It allows an individual to present their true self (at their workplace, school, etc.). |

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|---|---|
| **Bias** | **Bias** is a tendency to favour one group over another. Unconscious bias, also known as implicit bias, is defined as “attitudes or stereotypes that unconsciously alter our perceptions or understanding of our experiences, thereby affecting behavior, interactions and decision-making,” according to Marcelin et al. (2019). |
| **Bullying** | Repeated unreasonable behavior directed towards a worker or group of workers that creates a risk to health and safety (Safe Work Australia, n.d.). This includes bullying by workers, clients, patients, visitors or others. |
| **Harassment** | **Harassment** is intimidation based on personal characteristics such as age, disability, race, nationality, religion, political affiliation, sex, relationship status, family or carer responsibilities, sexual orientation, gender identity or intersex status (Australian Human Rights Commission, 2022b). |
| **Discrimination** | **Discrimination** occurs when a person is treated badly or unfairly compared to another person because of their background or certain personal characteristics (Australian Human Rights Commission, 2022b). Federal discrimination laws protect people from discrimination of the basis of their race (including colour, national or ethnic origin or immigrant status), sex, pregnancy, marital status, family responsibilities or breastfeeding, age, disability, sexual orientation, gender identity or intersex status |
| **Racism** | **Racism** is the process by which systems, policies, actions, and attitudes create inequitable outcomes for people based on race (Australian Human Rights Commission, 2024). It extends beyond prejudice in thought or action, occurring when this prejudice — whether individual or institutional — is accompanied by the power to discriminate against, oppress or limit the rights of others. |
| **Cultural safety** | **Cultural safety** is determined by Aboriginal and Torres Strait Islander individuals, families, and communities, with culturally safe practice requiring ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism (Australian Health Practitioner Regulation Agency, 2019). |

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|---|---|
| **Cultural responsiveness** | The ability to understand, respect, and appropriately respond to the cultural needs and practices of diverse populations (Hopf et al., 2021). It can be achieved through recognising cultural differences and incorporating this awareness into practice. |
| **Workplace culture** | **Workplace culture** is determined by the shared values and practices that characterise an organisation (Manley et al., 2011). |
| **Leadership** | The concept of **leadership** has been defined as the ability to influence, guide, and direct others to achieve common goals (Northouse, 2021). It involves setting a vision, inspiring others, and effectively managing resources and relationships (Dubrin, 2023). |
| **Leader** | A **leader** is an individual who influences, guides and motivates others towards achieving goals (Jones, 2007). |
| **Professional development** | **Professional development** is achieved through continuous learning and skill enhancement activities that help individuals advance their careers and improve their professional competencies (Williams, 2022). It includes training, education and experiential learning opportunities. |
| **Psychosocial risk or hazard** | **Psychosocial risks or hazards** refer to work-related factors that may have negative effects on an employee's mental health and wellbeing, such as excessive workloads, workplace conflict or exposure to traumatic events, etc. (Safety Australia Group, 2023). |
| **Critical mass** | **Critical mass** refers to the point at which change will occur. Critical mass theory in gender diversity terms explains that improvements in gender equity are not likely to occur until the number of women represented is substantial, often considered to be 30 per cent. |
| **Lived and living experience** | **Lived and/or living experience** is personal knowledge gained through direct, personal involvement in life events or circumstances. It also often refers to the insights and expertise of individuals who have experienced mental health issues, trauma, or other significant life challenges (Byrne et al., 2021). |
| **Workplace** | A **workplace** is any place where work is carried out or where a worker goes, or is likely to be, while at work (Work Health and Safety Act 2011 (NSW) s.8). |

| | |
|---|---|
| **Worker** | A **worker** is anyone who undertakes work for a person conducting a business or undertaking (Work Health and Safety Act 2011 (NSW) s.7). In health care, workers include all employees, such as administrators and support staff, doctors, health professionals, trainee doctors, support staff, students, subcontractors, labour-hire employees or volunteers. Legal duties extend to all those conducting work in the health care facility irrespective of their seniority and the nature of engagement. |

# 8.3 Appendix C: References


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