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August 5, 2005

Mr Mike Woods & Mr Robert Fitzgerald
Health Workforce Study
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Commissioners,

I am pleased to attach the submission to the Commission from the Urological Society of Australasia. I apologise to you that it is submitted slightly after the due date and thank you for granting us the additional time.

The Society would be pleased to provide any further information that you consider might be helpful. Should that be the case you should contact the CEO of the Urological Society, Professor David Barr at the above address or by email on davidbarr@urosoc.org.au.

Thankyou for the opportunity of making a submission.

Yours faithfully

Ross A. Cartmill
President

UROLOGICAL SOCIETY OF AUSTRALASIA

Submission to the Productivity Commission

(4 August, 2005)

The government is to be congratulated for having the Productivity Commission look into the long-term requirements of Australia's health workforce, especially as health related expenditure is going to require more government and private funding in the coming years. The present system delivers reasonable healthcare in most circumstances despite the publicity given to those occasions when it falls short of what is expected.

In no way does this Society wish to denigrate the efforts of those who have given and continue to give so much time to make the present system work. The initial and continuing education and training simply could not function without the voluntary work given by so many. But there are clear signs of strain emerging both in terms of patients' very reasonable high expectations of the quality of care and the resources that are available to meet these demands. It is good that there is to be a systematic study of the issues now so that changes can begin to be implemented before a crisis point is reached.

The scope of this inquiry is enormous so it is difficult for any one interest group within the health industry to stand back far enough to see the whole picture. These comments from the Urological Society of Australasia are relevant to urologists, are probably relevant to other groups of surgeons and may be relevant to other medical colleges. Presumably it is for the Commission to identify issues that have a broader applicability.

The Urological Society has chosen to identify some of the critical issues that the Society thinks need to be addressed by the Commission. The Society is of the view that the present system is not sustainable in the longer term and that there are major changes needed if the health workforce of the future is to deliver the healthcare that the Australian community will demand, at a reasonable cost to both the Government and consumers.

The Society has not provided solutions to the identified issues but should the Commission agree that any of the issues raised need to be addressed in the Commission's report, the Society would be pleased to provide further comment.

1. Systematic Lifelong Education for Doctors

The present education of doctors and specialist surgeons is conducted in a series of relatively isolated episodes. With the amount of change that will occur over any doctor's lifetime of practice it is crucial that there is a culture of lifelong education which is part of a planned and systematic continuum. There needs to be just as much attention given to continuing education as there is to initial training. If this occurs the public will have much greater confidence in medical practitioners and better quality care will be provided. Such a culture should also result in a lessening of medical litigation.

2. The Public/Private Nature of Healthcare in Australia

i) The Society considers that there is single health system which has one component which is *funded* almost entirely by the government, i.e. the so-called public system, and one that is *funded* by individuals and the government, i.e. the so-called private system. There is far too much overlap between these two components to consider them as two separate systems.

ii) Australians need to be clearly informed about how these two components differ in terms of the health outcomes for individuals. There are many different understandings of the public and private systems between different consumers, politicians, bureaucrats and people who work in the health industry. It is time these differences were made explicit, even if this is politically unpalatable, so the public can make properly informed choices.

iii) Because an ever increasing amount of healthcare is being provided within the private healthcare framework, and because it ought to be expected that every healthcare professional, including qualified surgeons, is continuously learning throughout their professional career, it is time that it was recognized that education and training should routinely occur in the private system as well as the public system. There is also the issue that some common surgical procedures are rarely performed in the public sector and new surgical techniques involving expensive equipment are often performed in private rather than public hospitals.

3. The Volunteer and *pro bono* Workforce involved in Specialist Education and Training

i) It is remarkable that an education system that depends almost entirely on voluntary and *pro bono* staff continues to survive. It is a huge bonus that surgeons want to give time to the planning and delivery of educational programs for new specialists and the continuing education of their colleagues. To ensure its long-term survival the system must be restructured so it functions on sound educational and business principles, hopefully retaining the current amount of goodwill as well.

ii) One wonders why the current system has survived for so long. Despite frequent criticisms and dissatisfaction with current practices there are obviously needs being met by the current system otherwise it is doubtful it would have survived for so long under such stress. But it is a fact that there are growing numbers of surgeons who do not choose to work in the public system. Specialists have limited time available to teach trainees because most of their sessional time in public hospitals is required to be spent treating patients. Sessional time in public hospitals is limited by State Government budgets and perhaps by shortages of specialists available to work in regional or rural public hospitals. This suits State governments because this means for the funds spent, both Visiting Medical Officers and Registrars spend more of their time reducing waiting lists.

What suffers is the quality of the training provided and ultimately the service to patients.

iii) Current surgical training programs still struggle to identify specific competencies of graduates, generally preferring to rely on written and final oral examinations and the global judgements of the surgeons who supervise the surgical skills part of the training. It is not that surgeons fail to see the benefit of identifying competencies. It is just that specialist training programs are designed by volunteer surgeons and supervised and assessed by *pro bono* supervisors who have little time to apply to such issues. There is a gradual incorporation of newer educational techniques but this is dependent on qualified urologists taking the time to learn and apply them to the training of new urologists. Realistically there are few incentives for this to occur.

iv) A number of surgical skills laboratories are being set up throughout the country which eventually should provide virtual models, cadaver and live animal practice opportunities before supervised surgery on human patients is undertaken and competency to operate independently determined. There is a limit to the amount of time volunteer surgical educators and *pro bono* surgeon supervisors can be expected to give to devising and supervising workshops in these laboratories, valuable as that would be. The same could be said for the on-line delivery of parts of the training program. In fact, virtually every decision made about improving the quality of the training or continuing education program is made in the knowledge that whatever is done is reliant on volunteer planners and *pro bono* supervisors. There is no time or funds provided in the current VMO system for research or improvement of adult education processes, eg competency assessment.

4. The Disparity in the Financial Rewards for Clinical Practice as against Research and Teaching

i) Any learned profession must have a commitment to growing the body of knowledge that informs its practice. It also needs a commitment to keeping abreast of the scholarship of others and disseminating that information amongst the profession. With a relatively small professional group such as urologists this is always going to be difficult but that does not make it any less important.

ii) There is little incentive in the present system for qualified urologists to become involved in the non-medical disciplines, e.g research design, statistics, curriculum design, adult education and educational measurement, which are required to make a serious contribution to research and education in their surgical specialty. The financial rewards of clinical practice are currently so much higher than those associated with research and teaching that it is always going to be difficult to get serious time commitment to these tasks.

5. Keeping Practising Surgeons Actively Involved in Education and Training

i) Under no circumstances should practising surgeons be sidelined from the training and research programs, as, for example, was the case when nursing became a university degree rather than a hospital training program. To do this runs the risk of an educational program which becomes fatally removed from the actual practice of the professions. It also recognizes that the lifelong education of surgeons is going to take place within their profession.

ii) Endorsing a system of training which involves practising surgeons will not only keep the training program linked to actual practice. It may also provide a means of addressing the gap between the financial rewards of clinical practice and research and teaching. It may also be a means of dealing with the geographic spread of the relatively small number of people in most training programs.

6. Payment Schedules to Surgeons

While remuneration is rarely the sole motivator of actions it remains one of the most important levers for shaping behaviours. If certain actions are better remunerated than others, those behaviours are likely to be repeated more often, all other things being equal. The ideal situation is that no one course of action is any better remunerated than another, so that there is no possible financial motivation to do anything other than provide the best possible care for the patient. A wise decision not to proceed with surgery ought to be proportionally just as well remunerated as the time that would have been spent doing the surgery, had that been necessary. There have to be broad-based knowledge and skill levels which are a pre-requisite for levels of payment. The challenge is to do this but still provide the financial motivation for surgeons to work productively in their private practices for the benefit of patients. This is unlikely to be achieved in a public service driven national health scheme.

7. Competition between Workforce Needs and Education Program Needs for Registrars

The competing demands of workforce needs of hospitals and educational quality needs of surgical training programs are difficult to satisfy. This is exacerbated by the fact that selection and training programs are federally driven while workforce issues are State-based so these issues easily degenerate into a non-productive Federal/State funding responsibility debate. There is dissatisfaction on the educational side that the training program is not more structured and predictable and there is dissatisfaction on the workforce side because trainees have to meet certain requirements of their program, some of which take them away from providing direct services to patients in the hospitals.

State governments seem to believe they are paying for a workforce to address waiting lists when they pay the salaries of Registrars and visiting consultants. Apart from minimal educational leave given to registrars and the need to have hospital posts accredited for training, there is little evidence that hospitals believe registrars are

engaged in a demanding educational program as well as the provision of patient care. To have the benefits of a workplace training program (see Section 5, above) it is essential to assign time and reasonable salaries to the training function. Current VMO rates would barely cover the overhead costs of a consultant's private rooms for the period she/he is working at a public hospital.

8. Needs of Regional Centres and the Rural Population for Specialist Services

The existing training program produces graduates who are most likely to practise at or near major teaching hospitals in big cities because that is where they will be more likely to see more patients requiring complex surgery. It is also where they are more likely to obtain a public hospital appointment. Relatively few graduates of the current program will go to the rural or regional areas where they must be generalists, even though there is demand for services in these areas. To compound this, there are fewer public hospital appointments available in rural and regional areas. At the moment even some larger regional centres would be financially marginal for a specialist dependant totally on private practice. So regional hospitals without a public hospital service will be more likely to attract less able practitioners. This is a high risk practice.

9. The Lack of Career Exit-Points during Surgical Training Programs

i) There would be few, if any, professional post graduate qualifications from which there is no exit point with identifiable vocational outcomes for at least six years. Such is the case in surgical training. It makes any effective workforce planning impractical. Would-be surgeons spend at least two years in a generic basic surgical training program and then at least four years in a specialist training program. There are some pressures to make the course of study even longer as the amount of material to be learned inevitably gets greater. There are other pressures to make it shorter to meet workforce needs which would have some advantages, but if this succeeds there will inevitably be more pressure for further training in sub-specialties.

ii) The current lengthy training program produces highly trained specialists who are unlikely to continually practise all the surgical skills they will have encountered in their training program. As the knowledge and skill base grows this will be even more so.

iii) The current single exit-point system makes it much more difficult to make use of overseas-trained surgeons who wish to work in Australia. While Australia needs their skills because of current shortages of Australian-trained specialists, it is difficult to place them in a system which has a single exit point. Creating special categories virtually reserved for overseas-trained doctors creates a hierarchy which can easily be interpreted as being racially based.

10. The Use of International Medical Graduates

i) Australia needs a long term policy to guide its use of international medical graduates (IMGs). It is repugnant for a first world country like Australia to recruit scarce medical graduates from developing countries which obviously need their own graduates to meet their own enormous needs. At the moment many IMGs are brought into Australia to work in parts of this country which cannot attract Australian-trained doctors.

ii) Australia needs sufficient qualified health workers (which includes doctors), trained in Australia to meet its own requirements and it needs programs that ensure the people in the more difficult areas to staff are provided with the right incentives to practise there.

iii) Australia should always be open to having internationally trained doctors coming to work in Australia. But the focus of this recruitment should not be on providing doctors in the most marginal areas at the lowest cost– rather it should be on attracting IMGs who can lift the overall quality of Australian healthcare.

11. Possible Conflict of Interest between Professional Colleges and Decisions made about Initial Training Programs.

Following the recent criticisms of the Royal Australasian College of Surgeons (RACS) by the Australian Competition and Consumer Commission (ACCC), the College was given authorization to provide surgical training for six years, subject to the College meeting certain conditions. In other words, if the conditions are met, the ACCC believes there will be no anti-competitive outcomes from the RACS training program. But this will be reviewed at the end of six years.

In the time frame of surgical training, six years is a relatively short period. The Productivity Commission needs to secure the long term future of the training of surgeons. There will probably always be some concerns that there are conflicts of interest between a body representing independent practitioners and the same body exerting a great deal of influence over decisions about the number of specialists in training. The Commission should take steps to secure the provision of the surgical training program and perhaps other specialties. Surgeons and the College should not have any doubts about who will be conducting surgical training for the foreseeable future. Whoever provides that training ought to be in the position of confidently making long-term decisions.

Conclusion

To date it would appear that the Australian community has been the beneficiary of a tradition of largely unpaid surgical training which has produced standards of care which are the envy of much of the rest of the world.

But as the demand for healthcare grows over coming years and the standards of care demanded by the community also continue to rise, it seems fairly obvious that it will not be possible to keep expecting more and more virtually unpaid assistance to keep the system functioning.

The Society applauds the decision to look at the long term issues associated with the health workforce in Australia. It will be pleased to provide further information or advice should that be required.

Ross A. Cartmill
President
Urological Society of Australasia.