Australasian College of
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SUBMISSION TO

PRODUCTIVITY COMMISSION

HEALTH WORKFORCE STUDY

The Australasian College of Podiatric Surgeons

Executive summary

Podiatric surgery in Australia represents a case study of the issues the workforce study seeks to examine. Barriers do exist within the Australian health care system that reduce competition and workforce substitution in the field of foot surgery.

The Australasian College of Podiatric Surgeons (ACPS) recognises and applauds the efforts of the government in fostering reform of the health system. This submission seeks within the terms of reference to provide direction on means to allow the Australian public the opportunity to benefit fully from the process of workplace reform using podiatric surgery as a case example.

This submission after an introduction and background address‘s the relevant terms of reference. We would like to draw particular attention to our comments in section 4 and 4(a) which is a summary of our current priorities and where we see the future role is for podiatric surgery in the health care system.

The ACPS is a small organisation representing an emerging workforce in Australian health. Our resources are limited and submissions such as this are generated through significant individual contribution. Further information and supporting evidence to any aspect of this submission can be made available upon request.

Mark Gilheany
President ACPS
July 2005

Introduction

We have placed this submission within our understanding of the policy context of the federal government's aim to promote enhanced competition in Australia and its governance of the health system over the next couple of decades. This context of national competition policy framework is important, as this mode of governance determines the shaping and ends of policy; the way reform will be undertaken to ensure their compatibility with market freedom, the instruments used to manage the health system and the public law to regulate the health of the population.
We agree with the policy framework and the ends of governance, as they were mapped out in the Treasury's *The Intergeneration Report 2002-200/.* There, it is stated that:

> "The overarching objective of the Government's economic policy is to improve the wellbeing of Australians in a way that can be sustained over time. This is related to both the current generation of Australian and future generations. The Government's policy framework aims to ensure that economic, social and environmental policies compliment each other to bring about sustainable improvements in wellbeing." (p.13.)

We also agree with the Productivity Commission's argument in *its 'Impacts of Medical Technology in Australia*' report that advances in medical technology are a major driver of increased private and public expenditure; and that it is economically unsustainable to continue to use advances in medical technology as the principal way of improving the health of the population. Some rationing of high technology is required as the costs per head of population are too great.

The emphasis in the Productivity Commission's recent *Economic Implications of an Ageing Australia',* which looked at Australia's demographic transition to older population, is on escalating health costs on the grounds that sickness and disability rises with age along with the costs of hospitals, high technology and drugs.

The question that needs to be asked is: is the traditional approach, with its conception of health care, the best way to deal with the future health care problems highlighted in the *Intergenerational Report.* The goal of public policy should remain on wellness of the population; and not on just reducing costs, a more flexible healthcare labour market, and better coordination across services and jurisdictions as ends in themselves.

Argument of Submission

Our submission is primarily concerned to highlight the way that better health outcomes can be achieved through more efficient and effectively functioning markets. We suggest that the experience of podiatric surgeons in the health system highlight that a more competitive health market can be achieved by removing those impediments to the health market that have historically functioned to restrict competition and protect closed shops.

There has been a history of blockage in relation to the provision of surgical services by podiatrists by the medical profession that uses its power to defend its sectional interest. The latter effectively lobbying against podiatric surgeons through acting as a trade union defending anti-competitive practices. The grounds are that the scope of practice of podiatrists should be restricted and should not include surgery.

Consumer access to the services of podiatric surgeons still face significant barriers, despite the federal legislative changes aimed at removing anomalies, which have historically prevented the development of podiatric surgery as ancillary support to the Australian health sector. These barriers include

- state regulations defining medical practitioner that does not include podiatric surgeon
- access to public hospitals
- unwillingness of the private health insurance to provide rebates for services provided by podiatric surgeons
- no rebates to medical practitioners (eg. anesthetists, pathologists, radiologists) who provide services to the patients of podiatric surgeons and are integral in the surgical care of patients.
- No uniform or national access to prescribing privileges for the independent management of their patient's pharmacological needs

These barriers and systematic constraints give rise to inefficient markets by muting price signals, distorting patterns of health service consumption and constrain workforce substitution.

Our submission to the health workforce study is made from the perspective that the tools used to achieve competitively and effectively functioning markets can be deployed to deliver better health outcomes. We hold that political power should continue to use National Competition Policy as one of the key driver in creating a more efficient and better functioning health market, since the key objective of this policy is to develop a more open and integrated Australian market that limits anti-competitive conduct where it is in the public interest to do so. It is in the public interest to have a health market that is more efficient and better functioning than it is now.

Background

Podiatric Surgery as a discipline has existed in Australia since 1978 so can be regarded as small emerging professions with currently only 25 podiatric surgeons working within Australia, with a similar number of trainees. It exists internationally on a much wider scale in the USA where 80% of all foot surgery is performed by podiatrist's and in the UK where there are 52 podiatric surgical units within community trusts.

Prior to 1978 and for some time after, the majority of foot surgery in Australia was performed by general orthopaedic surgeons and by their own admission the quality of foot surgery was less than adequate. Competition generated by the emergence of podiatric surgery saw the development of the Australian Orthopaedic Foot and Ankle Society which oversees the training and accreditation of orthopaedic surgeons with a special interest in foot and ankle surgery. This resulted in a smaller sub specialty group which is more highly skilled than general orthopaedic surgeons in foot and ankle surgery.

The current situation is that we have two separate professional groups, podiatric surgeons and orthopaedic surgeons, providing the same service however the level of recognition and constraints placed upon podiatric surgeons is far greater despite the federal government intention of providing a more even balance through some of the recent legislative amendments [Health Legislation Amendment (Podiatric Surgery and Other Matters, 2004) Act.].

The training of a foot and ankle surgeons through the traditional medical model has seen the level and period of training increase in more recent years to meet the standard of care expected by the public. Training now consists of a 6 year undergraduate medical degree followed by a period of time of practice prior to entering into a specialist training program as an orthopaedic surgeon. While foot and ankle surgery is practiced by general orthopaedic surgeons, to be accredited in the sub specialty of foot and ankle surgery requires an additional 1-2 years of training. This means a total training time of approximately 16 years.

This is in contrast to the training of Podiatric surgeons who complete a 4 year undergraduate degree followed by a 2 year period of postgraduate experience before entering a postgraduate Masters degree along with a practical training program. The total training time is approximately 8 -10 years.

The training program of podiatric surgery is more focussed on the task that is required within the work place rather than a broader model of medical training which then filters back down to a narrow focus. The podiatric model of training is much more cost effective due to the shorter, more focused training and will also allow much quicker response to workforce needs in the future. The argument used by orthopaedic surgeons is that podiatrists do not have the medical background and are therefore

unsafe. There has been no evidence to support this claim. It is more based more on the concern that the level of training is not the same as their own. Health outcome studies comparing the results of foot surgery performed by orthopaedic surgeons to those of podiatric surgeons have shown podiatric surgeons to generally produce better outcomes than orthopaedic surgeons.

Historically podiatric surgeons have performed the majority of surgical procedure in day surgery or on an outpatient basis which predates the move by medically trained surgeons to the greater utilization of day surgery.

Patch protection has been very common in health care industry. The argument by most professional organizations has been to “maintain standards” and for the safety of the public.
The podiatry profession can be accused of patch protection but has been revaluating its position within the health care industry and has embraced the concept of workforce substitution. An example being the change in policy of the Australasian Podiatry Council on podiatry assistants where lesser trained individuals are being utilized to provide basic footcare needs. It is more cost effective and helps ease the shortage of general podiatrists who are able to carryout more complex footcare needs in the increasing aged population.

The Royal Australasian College of Surgeons has not been so forthcoming in allowing podiatric surgeons as a substitute workforce expressing concerns about the level of training and concerns about public safety despite the fact that podiatric surgeons have been shown to be safe and effective. These sentiments were expressed in recent federal parliamentary debates.

Traditionally it has been the Royal Australasian College of Surgeons who has the majority of control over the training and supply of surgeons. One of the reasons podiatric surgeons have so much opposition from the Royal Australasian College of Surgeons is that they work outside of their traditional training methods and control.

Training regimes based on traditional professional demarcations have created the situation where podiatric surgeons are forced and are often perceived to work outside of the mainstream medical system despite their desire to be more integrated.

Podiatric surgery is a cross over profession which does not conform neatly neither within either the traditional allied health or in the medical/surgical hierarchy. As a small emerging profession it is struggling in an environment which has systemic and regulatory constraints maintained by governments, private health insurers and the model under which the current health care system operates. Many of these constraints can be perceived as being anti competitive.

It can be argued that the overall standards of foot surgery have increased since the evolution of podiatric surgery in Australia due to increased competition albeit on an uneven playing field where podiatric surgeons struggle for recognition and survival.

ADDRESSING TERMS OF REFERENCE:

1. Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention;

- Podiatric surgeons continue to face significant barriers, despite the legislative changes aimed at removing some of the anomalies which have historically prevented the development of podiatric surgery as ancillary support to the Australian health sector.
- Established medical institutions, such as public hospitals, effectively exclude access to podiatric surgeons through hospital bylaws. It is only the Daw Park Repatriation General Hospital in Adelaide, South Australia, which grants access via a public hospital and is limited to 1 half day session per week.
- At Daw Park Repatriation General Hospital the funding arrangements are based upon a formula passed down from the Commonwealth which does not recognize the surgical services performed by podiatric surgeons. This means the hospital receives funding based on an allied health practitioner which is not representative of the surgical service provided.
- Some state regulations and laws block access to podiatric surgeons through the definition of medical practitioner - the definition does not recognizing podiatric surgeons.
- While two states allow for podiatric surgeons to prescribe a limited range of drugs, podiatric surgeons have been unable to obtain uniform or national access to prescribing privileges for the independent management of their patient's pharmacological needs. In those states where Podiatric surgeons have drug prescribing privileges they have a low drug prescribing habits as drugs needed for surgery are commonly only used for short duration so do not represent high cost drug usage for long duration.
- The supply of podiatric surgeons is constrained due to the lack of availability of training opportunities in the public health system. Podiatrists who otherwise would consider a career in podiatric surgery, leave the profession this represents a lost workforce who then seeking retraining in other fields which offer a better career opportunity.
- The above factors discourages the supply of podiatric surgeons as ancillary support to the Australian health sector, and underutilizes the role that they can play, consequently, there is room for the federal government to ensure that appropriate reforms are put in place to facilitate the development of podiatric surgery as an integral part of the Australian healthcare sector. Reform should be directed at ensuring improving access of podiatric surgeons to both private and public facilities which provide acute care (surgical services). Establishment of podiatric surgical units in public hospitals with training programs is essential to foster the development of podiatric surgery.

1(a) the effectiveness of relevant government programmes and linkages between health service planning and health workforce planning;

- There is no health service or health workforce planning with respect to podiatric surgery. Podiatric surgeons are a small profession and are simply overlooked even though the federal government's legislation recognizes podiatric surgeons in terms of professional attention along with medical practitioners, dentists and midwives [Health Legislation Amendment (Podiatric Surgery and Other Matters, 2004) Act.].
- The linkages between the different medical professional bodies representing podiatric surgeons and orthopaedic surgeons are casual; rely on personal contact, rather than being fostered by any workforce planning or programs; with union contact taking an adversarial form.
- The Department of Health and Aging has been slow to implement the intent of recent legislative amendments, despite the federal government's recognition of podiatric surgeons as providers of professional attention.
- The states, (eg NSW) have been slow to bring their legislation into line with the commonwealth. As a result, podiatric surgeons have been excluded from the private health system because they are not medical practitioners.
- There are no Medicare rebates for podiatric surgeons even though an identical service provided by an orthopaedic surgeon will attract a Medicare rebate.
- The private health insurance industry is reluctant to consider any rebates for podiatric surgery unless the government provides a Medicare rebate for the services of podiatric surgeons. Concern by the private health insurance industry are about cost shift from the commonwealth to the private sector for a surgical service which would be otherwise rebated by the commonwealth if provided by an orthopaedic surgeon.
- There has also been a marked failure by the private health insurance industry to appropriately support hospital costs associated with podiatric surgery. This refusal by the health funds is discriminatory and is hidden from the consumer who has purchased health insurance.
- Lack of Medicare rebate for medical specialists upon direct referral from podiatric surgeons.

1(b) the extent to which there is cohesion and there are common goals across organisations and sectors in relation to health workforce education and training, and appropriate accountability frameworks;

- Despite the common goals embodied in the university and clinical education of the podiatric and orthopaedic surgeons to reduce health care costs and achieve better health outcomes, there is no coordination or collaboration in the design of the training programs of podiatric and orthopaedic surgeons.

- There is commonality with respect to accountability frameworks of hospitals that grant podiatric and orthopaedic surgeon's privileges for accreditation.

1(c) the supply, attractiveness and effectiveness of workforce preparation through VET, undergraduate and postgraduate education and curriculum, including clinical training, and the impact of this preparation on workforce supply;

- Whilst there is a shortage of podiatrists providing general services there is no shortage of graduates entering the postgraduate training program and undertaking the theoretical component of their training as podiatric surgeons.

- The bottleneck is the lack of clinics for the hands on or practical clinical training provided by the public hospitals. Currently the training is predominantly run through international rotation and the private system which is not necessarily equipped to train surgeons. Most surgical training is best undertaken in a public hospital facility affiliated with a University Medical school. For Podiatric surgery this currently happens on an adhoc basis with minimal formal articulation or coordination with other medical/surgical training programs.
- There are no funding arrangements in place for training programs for podiatric surgeons in the public hospital system.
- Undergraduate podiatry programs such as at the University of South Australia function with part-time staff and limited resources, as the significant part of the teaching is one based on volunteered time by part-time staff. Increased funding for and or rationalization of podiatry undergraduate courses is required.
- More Doctoral research in podiatric surgery needs to be fostered through the support of postgraduate programs within podiatry and medical schools.

1(d) workforce participation, including access to the professions, net returns to individuals, professional mobility, occupational re-entry, and skills portability and recognition;

- Podiatric surgeons are recognized by the federal government as providers of professional attention but this has had little effect on recognition by state governments, private health funds and the medical colleges.
- The public health system is slow in its system evolution of recognizing professional attention.
- There are very limited opportunities for publicly employed podiatric surgeons in hospitals. As mentioned previously the Repatriation General Hospital in Adelaide offers only 1 session per week.

1(e) workforce satisfaction, including occupational attractiveness, workplace pressure, practices and hours of work;

- Frustration is articulated by consumers and practitioners around payment for services, this has been documented by the Private Health Insurance Ombudsman.

- There is no award payment for podiatric surgeons within the public system. At present they are remunerated as an allied health practitioner with no recognition for their surgical skills despite higher level of responsibility and training.
- Private health funds refuse to pay rebates on foot surgery performed by podiatric surgeons so large numbers of patients cancel and turn to orthopaedic surgeons who are recognized by private insurance providers and Medicare.
- Existing podiatric surgeons are placed in severe stress due to current uncertainty of income and employment.
- Due to underutilization of their surgical skills many podiatric surgeons continue to provide general podiatry services so as to be able to continue providing an income.

1(f) the productivity of the health workforce and the scope for productivity enhancements.

- There is no publicly available federal data specific for waiting times for foot and ankle surgery, though there is probably data within the state health systems. We do have indications that better health care can be achieved through a redistribution of existing resources.
- Productivity of work force around foot surgery is constrained by many of the factors mentioned previously in this submission
- There is underutilization of podiatric surgeons for basic surgical footcare and an over utilization of highly trained orthopaedic surgeons.
- Obstacles to workforce substitution by podiatric surgeons lessen productivity.
- The shortened educational timeframes for podiatric surgeon (8 -10 years compared to 16 years for medically trained orthopaedic foot and ankle surgeons) means that waiting lists can be addressed more quickly.
- There is no public calculation of the actual cost savings associated with significantly shortened time frames.

2. Consider the structure and distribution of the health workforce.

- The current structure of the health workforce gives rise to inefficiencies in delivery of surgical services, due to the exclusion of podiatric surgeons.

- Minimal podiatric surgical health services provided in the regional areas even though there are podiatric surgeons available to provide a service but the barriers mention previously prevent their workforce participation.

2(a) workforce structure, skills mix and responsibilities, including evolving health workforce roles and redesign, and the flexibility, capacity, efficiency and effectiveness of the health workforce to address current and emerging health needs, including indigenous health;

- The existence of professional silos means that there is very little cross over amongst the disciplines. Podiatric surgeons are a case in example where they are an allied health practitioner providing services in an area traditional serviced by medically trained surgeons.

- There are no podiatric surgical services for indigenous footcare, even though the indigenous population has a high rate of diabetes and, as a result, serious foot problems.

2(b) analysis of data on current expenditure and supply of clinical and non-clinical health workers, including the development of benchmarks against which to measure future workforce trends and expenditure

- Public hospital's waiting lists for minor surgical foot procedures are characterised by increasing waiting times.
- If these procedures are delegated to podiatric surgeons, then this workforce substitution would allow the orthopaedic surgeons to concentrate on more complex hip, knee and spinal surgery for which they are trained.
- Podiatric Surgeons perform the majority of procedures on a same day basis. This means that high quality, cost effective and safe foot and ankle surgery is performed on the same day reducing burden on inpatient hospital resources.
- Queensland Health public hospital data from the previous 4 years demonstrate that hospital length of stay for elective foot and ankle surgery to be 2-4 times longer than that performed by podiatric surgeons.

2(c) the distribution of the health workforce, including the specific health workforce needs of rural, remote and outer metropolitan areas and across the public and private sectors.

- Though there are podiatric surgeons in these regions who are willing to provide services, due to the constraints mentioned previously, this limits their ability to meet consumer demand

3. Consider the factors affecting demand for services provided by health workforce professionals.

- Demand is increasing due to the aging of the population. The high demand for foot care in the ageing population is discussed in detail within in the Australian Podiatry Council submission

(a)distribution of the population and demographic trends, including that of indigenous Australians

- The high level of diabetes means foot problems and high level of intervention required. Again this topic is discussed in more detail within in the Australian Podiatry Council submission

(b) likely future pattern of demand for services, including the impact of technology on diagnostic and health services; and

- Demand is increasing, as indicated by waiting lists in public hospitals primarily for older people

- Private services are available for those who can afford to pay through private health insurance.

- Podiatric Surgery is a low user of high technology. When required, access for patients of podiatric surgeons to high technology such as ultrasound, CT scan and pathology, this requires additional Medicare expenditure as the referral has to be directed through a medical practitioner therefore requiring an additional consultation.

3(c) relationship between local and international supply of the health workforce.

- The shortage of surgeons in Australia means that surgeons have to be bought in from overseas to plug the gasps. Yet we have a workforce of locally trained podiatric surgeons who can be deployed to ease the shortages through workforce substitution.
- Need to bring podiatric surgeons into the medical surgical culture through fostering a cross over between allied health and surgeons. Models for this already exist such as dentists and oral surgeons.
- The training of podiatric surgeons in Australia is on par with UK and USA however there is under utilization and recognition of podiatric surgeons in Australia in comparison to overseas.

4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term.

The following are all high priorities and are easily attainable in the short to medium term if the government is serious about reforming the health care system and encouraging competition within the health sector. In our opinion theses recommendations do not represent additional cost to the health care system but would immediately encourage greater efficiency in the health care system through competition that does not discriminate between the providers of foot surgery.

- Private medical insurance funds need to fully inform the consumer about their unwillingness to pay rebates for hospital costs incurred in surgical procedures performed by podiatric surgeons. If taking such a policy stance it should be justified in evidence.

- Workforce substitution of podiatric surgeons with orthopaedic surgeons for foot and ankle surgery as this is a better utilization of public recourses, as it frees the latter to do the more complicated hip, knee and spinal surgery for which is also in high demand.

- The barriers that exist to prevent the more cost effective use of podiatric surgeons to provide the unmet demand for foot surgery need to removed, as these represent a restraint on trade, are anti-competitive, and short change consumers.

- The federal government to reimburse anaesthetists and other medical specialist services as required to support the surgical episode for patients operated on by podiatric surgeons

- Uniform prescribing privileges in all states for drugs needed to support the surgical episode for patients operated on by podiatric surgeons.

4(a) practical, financially-responsible sectoral (health, and education and training) and regulatory measures to improve recruitment, retention and skills-mix within the next ten years.

Short term**:**

- The state and other federal regulatory frameworks needs to be bought into line with professional attention recognition.
- Funding mechanisms for podiatric surgery need to be considered including private health insurance, creation of public hospital positions and other forms of federal funding to recompense for the cost of surgical services performed by podiatric surgeons

Medium term**:**

- There is a need to reform the process of training surgeons in Australia to take advantage of the shorter educational time frame of the podiatric surgeons.
- Creation of training positions in public hospitals that has linkages with the other medical/surgical specialties

Long term:

- Complete integration of podiatric surgeons within a reformed health care system that takes advantage of the market forces created by increased competition.

4(b) ongoing data needs to provide for future workforce planning, including measures to improve the transparency and reliability of data on health workforce expenditure and participation, and its composite parts.

- The USA and UK utilize podiatric surgeons in the public and private health system much more than happens in Australia. The majority of consultant surgeons in the UK NHS with a specialty in foot and ankle surgery are podiatric surgeons.
- Research in the UK has highlighted that once podiatric surgery becomes established in a health district, general practitioners often prefer to send their patients to podiatrists for foot surgery, rather than orthopaedic surgeons. Access to podiatric surgical services improves the mobility of the aging population

5. Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.

The availability of orthopaedic surgeons for after hour's emergency care can be a problem. Podiatric surgeon are able to act as a substitute workforce in place of orthopaedic surgeons in providing after hours care acute care for foot and ankle injuries if they were provided the appropriate recognition previously in the document.