Executive Summary

The Royal Australasian College of Surgeons (RACS) welcomes the Productivity Commission's research study into the Australian health workforce. It is time a sensible, independent and evidence based approach to workforce issues was undertaken to better inform a debate that to date has been characterised by political point scoring, scapegoating and key opinion leaders repeating urban myths as fact. It is time for some clarity, data and a shared understanding of the real problems before the increasing frustration felt by those working in the healthcare system makes it too late for cooperative solutions to be developed.

There is an increasing demand for surgical services in Australia, estimated to grow 50% by 2012. Demand has largely been driven by an ageing population, but not exclusively so. This will require the training of additional surgeons; a position the RACS has supported for over a decade.

Professional standards are vital if Australia is to retain its reputation of providing surgical services of the highest quality. But standards have to be set at the right level, for if they are too high it will result in access and price barriers to patients. In 2000 the RACS sought to have this balance tested with the ACCC and received Authorisation in 2003. There is no tougher test in Australia and the RACS was justifiably pleased to pass (with conditions that have been or are being met). The RACS therefore firmly rejects any suggestion that it operates as a 'closed shop' or that its standards are too high.

There is some inefficiency in the Specialist Surgical Training program, but the real barrier to training more surgeons is inadequate funding.

The RACS is committed to reducing those inefficiencies and reducing the length of time it takes to train a surgeon. Specialist Surgical Training should be a continuum from the start of Basic Surgical Training (BST) to completion of Specialist Surgical Training (SST). At present 90 doctors who have passed the BST are in limbo, biding their time while waiting for a funded SST post to become available.

Governments need to provide adequate funding for SST posts. There is no point increasing the number of Basic Surgical Training posts if there is not a corresponding increase in the number of SST posts. SST posts need to be increased from around 800 currently to 1000 – and the funding needs to be found urgently.

Surgical services are also delivered as part of a surgical team. Within that team greater efficiencies can almost certainly be found. Such moves are likely to give greater gains with less risk to patients and service delivery than creating a new class of provider independent of the surgical team.

The number of surgeons is but one factor in Australia's ability to deliver surgical services in the public sector. Others include the availability of operating theatres, pre and post operative hospital beds and efficient work practices. Unless these are addressed increasing the number of surgeons will do nothing to reduce public hospital waiting times.

The Demand for Surgery and the Supply of Surgeons

Demand for Surgical Services

In 2003 the RACS commissioned a study by Birrell[4] and others to examine the outlook for surgical services in Australasia. (The paper by Birrell is a comprehensive examination of the surgical workforce in Australasia and is as relevant today as it was in 2003. It also covers the structure and distribution of the surgical workforce. A copy of the paper is located on the College website.)

Birrell noted that the demand for surgical services seemed to be largely generated by the ageing of the population but it was not the only factor. New surgical techniques and procedures are constantly being developed with trend data from Victoria indicating that "innovations which diminish the need for surgery are being overwhelmed by developments which increase the capacity of surgeons to operate usefully".

He also hypothesised that demand for surgical services, at least in the private sector, had been boosted by the Australian Government's subsidies to private health insurance in early 2000. Insofar as that increase was a result of a reduction in the out of pocket expenses for patients, the 2004 Medicare Safety Net changes can only have increased demand, even if only for out of hospital surgical consultations.

Adding these together he conservatively estimated there will be at least a 50% growth in demand for surgical services by 2021.

However, to assume we can match the demand for surgical services in Australia by just increasing the number of Australian trained surgeons is too simplistic. The number of surgeons is only one factor that influences the supply of surgical services. Others include the availability of operating theatres, pre and post operative hospital beds, efficient work practices and the availability of Overseas Trained Doctors to fill gaps.

The number of Australian trained surgeons does need to be increased but there are a number of barriers to that occurring.

The Supply of Surgeons - Barriers and Inefficiencies

As at December 31 2004 there were some 3600 active surgeons in Australia[2] and for over a decade the RACS has been highlighting an impending shortage of surgeons[3].

Based on current work practices and efficiencies, in order to meet the estimated 50% increase in demand for surgical services by 2012, Birrell[4] suggested that 195 new surgeons would need to be added to the workforce each year. The RACS has been increasing the number entering Basic Surgical Training (BST). In 2004 the RACS accepted 220 doctors into BST and has proposed that for 2006 it accepts between 220 and 259 doctors dependent on the increased availability of specialist surgical training posts.

However, increasing BST numbers is only part of the story. The number of surgeons is determined by a delicate balance between setting professional standards high enough to guarantee quality while not so high as to be an unreasonable barrier to supply. Despite that balance being tested and authorised

by the ACCC, the media and senior opinion leaders have yet to catch up the facts and the real barriers to increasing the number of surgeons.

Balancing Professional Standards

The Royal Australasian College of Surgeons is justifiably proud of the quality of surgeons that pass through and graduate from its training programs. The RACS can rightly claim that Australasian surgical standards are among the highest in the world.

However, there is a balance between professional standards and public benefit. If the standards are too high then the numbers who can meet those standards might be restricted, with consumers experiencing access and price barriers to services; if standards are too low the quality of services might fall, with an increased risk of adverse events and poor outcomes for consumers. Getting that balance right is a challenge and, given the severe penalties under the Trade Practices Act, a significant risk for the RACS if it was found to have breached the Act. In November 2000, as part of managing that risk, the RACS sought to test whether it had the correct balance by applying for authorisation from the ACCC for processes in relation to:

- the selection of trainees for all specialities in which it conducts training;
- accrediting hospitals and hospital training posts as being suitable for basic and specialist surgical training; and
- assessing the qualifications of overseas-trained practitioners.

In June 2003, and after extensive public consultation, the ACCC granted authorisation with conditions pursuant to which the College administers processes until 2007 for:

- assessing overseas-trained surgeons;
- accrediting hospitals for basic surgical training; and
- accrediting hospital posts for specialist surgical training.

And until 2009 for:

- selecting basic and specialist surgical trainees;
- training basic and specialist surgical trainees; and
- examining basic and specialist surgical trainees.

(The RACS submission, ACCC response and authorisation, and the recommendations of subsequent reviews are available on the College website).

The RACS' processes were thoroughly examined by the ACCC and subjected to intense public scrutiny, with nearly one hundred submissions from other interested parties. The ACCC's view was that the current arrangement, wherein the RACS has sole control of Australian surgical training, was anticompetitive but the public benefit gained by the high standards and pro-bono contribution to training by surgical Fellows was such that, subject to some conditions, it should be authorised to continue. The authorisation conditions have now been or are being met by the RACS, with the RACS Council recently endorsing all of the recommendations made by the two reviews required as part of the authorisation (the Review of the Criteria for Accrediting Hospital Training Posts for Advanced Surgical Training and Hospitals for Basic Surgical Training and the Review of the Assessment of Overseas-Trained Surgeons).

Apart from meeting the requirements of the ACCC, the surgical training program must also be accredited by the Australian Medical Council (AMC). The AMC is an independent national standards body for medical education and training whose mission is "To promote and protect public health and safety by ensuring a safe

and competent workforce distributed across Australia to meet community needs." In 2001 the RACS was among the first colleges to undergo and pass this rigorous accreditation process and will do so again 2008.

There are no stiffer tests in Australia and the RACS had some justification in feeling this issue had finally been put to rest.

The RACS was therefore annoyed when media reports indicated that the Treasurer, Peter Costello, had singled out surgeons when announcing the Productivity Commission Health Workforce Study, as reported in this story by Sue Dunlevy in the Daily Telegraph.

"Surgeons could lose their cosy work deal"
Daily Telegraph 16/03/2005 - Sue Dunlevy
THE closed shop by surgeons, which limits their numbers to keep up their incomes, is to be scrutinised by the nation's efficiency guardian. Treasurer Peter Costello has ordered the Productivity Commission to investigate roadblocks in the way of training doctors – and he has surgeons in his sights. "There is a concern that in relation to specialist training, not as many specialists are being trained," he told Federal Parliament yesterday. He said, with the population ageing and demand for medical services on the increase, the Government wants to remove any barriers to increasing doctor numbers. It is estimated there are already 2000 to 3000 general practitioners – foreign doctors are being imported to cope with the shortage in the bush.

The article, if it truly reflected the views of the Australian Treasurer, demonstrated a marked ignorance of the benefits to the community of RACS' professional standards, the rigorous examination of the College conducted by the AMC and the ACCC, and of the RACS' subsequent compliance with the conditions of the ACCC authorisation.

There are barriers to training more surgeons, but if the ACCC authorisation proves anything, it is that the RACS is not the body responsible for those barriers.

Specialist Surgical Training (SST) - Inefficiencies and Barriers

Surgical training is at present a two stage process involving basic and specialist surgical training. The aim of Basic Surgical Training (BST), which usually starts in the second or third year after graduation, is to provide trainees with the basic skills and knowledge required for entry into a Specialist Surgical Training (SST) program. It usually takes three to four years and requires knowledge of specialist anatomy and basic surgical techniques.

If they pass their basic training assessment and find a funded and accredited specialist training position, trainees can enter specialist surgical training in one of the nine surgical specialities where they are provided with the skills, knowledge and expertise needed to become a specialist surgeon able to practice independently in a range of hospitals and practice settings. Specialist surgical training can take four to six years to complete.

While high quality surgical skills cannot be gained overnight, the RACS is committed to finding ways to reduce the time it takes to complete training. The RACS is aware this could result in a reduction in the standard of surgical services, but hopes newer educational techniques, including surgical skills centres and better structuring of the training program, can reduce the time taken without reducing quality.

One structural problem is the lack of continuity in the two stage training process. Trainees who enter and pass the basic surgical training do not automatically move into specialist surgical training. They often wait in limbo unable to find a funded and accredited specialist training position.

There are 90 doctors (60 Australian graduates and 30 overseas trained doctors) currently in this situation. While they might be working in the health care system, they are not training to be surgeons. With increasing numbers in basic training this group will only grow unless urgent steps are taken to fund more SST positions.

There are plenty of surgical posts that could be accredited as specialist training positions if funding were available. The source of that funding is outside the RACS' control and rests with the Australian and State and Territory governments. The RACS called on governments to provide the necessary funding on 10 May 2005[5].

This would give a one-off increase of 90 surgeons within four to five years, rather than a ten year wait if starting with medical graduates or a fifteen plus year wait from the beginning of the undergraduate medical course. Furthermore, current BST numbers can ensure an increase of 30-40 more trainees per year into Specialist Surgical Training for Australia and NZ from now on.

BST positions are cheap for funders and BST trainees do not perform surgery independent of their trainers. SST trainees on the other hand, as their expertise increases, can be serious contributors to surgical services. However, SST positions cost money and this is where the major problem lies. Not only do SST trainees require funding for their salaries, they also generate considerable downstream costs by performing surgery. In addition, there needs to be more surgery occurring for SST posts to have sufficiently high levels of activity to ensure high standards for training. Funders are much happier increasing the number of BST posts as they can be used as clerical cannon fodder for out of hours doctor rostering and not generate additional costs by increasing throughput of surgical cases.

It angers surgeons that they are blamed for creating barriers to more surgical trainees when the real barrier is lack of funding.

If governments are serious about increasing the numbers of surgeons they should immediately fund the additional 90 training places for those doctors who have completed their BST and can enter SST immediately.

Delivering Surgical Services by other than Surgeons

The RACS believes the public has the right to have surgical procedures performed only by those competent to do so and to be fully informed of the risks of such a procedure in the hands of the person performing it. In particular, being 'fully informed' requires a comparison between the person who might perform it and his or her peer group, and other groups who might perform the procedure.

The RACS is not concerned by competition from other providers. Its only concern is for the quality of the outcome of the surgical service. Surgeons already compete among themselves, with other medical practitioners and against a 'free' public hospital system in which many, as Visiting Medical Officers, provide a great deal of the surgical services. GPs (especially some rural GPs) do everything from removing moles to delivering babies, treating fractures and abdominal surgery. Many other specialists perform surgical procedures related to their discipline without involving a trained surgeon. While the RACS has quality concerns about some of these practices, at least within the medical model there are multiple levels of safeguards to protect patients.

However, having surgical services performed by other providers could reduce the efficiency of existing surgical services and potentially leave patients exposed to a double whammy of a greater risk of adverse events and lack of indemnity cover.

There seems to be little point moving towards a system that would see narrowly trained individuals, even non-medical practitioners, performing a very restricted set of surgical services. Training someone specifically to do one procedure flies in the face of the logic of having a flexible 'generalist' workforce. There is nothing more super-specialised and less flexible than having a person trained in only one procedure and unable to deal with an unexpected finding or an unusual consequence of surgery.

The delivery of surgical services requires a complete team. The risk in service substitution is that some members of that team might be lost, with a resultant loss of efficiency. A far better strategy would be for members of that team to use modern change management processes to critically examine how they deliver their services and be prepared to consider redefining their roles within that team if it results in improvements in care and efficiency. Redefining roles within the surgical team might also have other efficiency gains. New surgeons might not need to learn some aspects of a procedure, with the potential to reduce training time.

Models of service substitution that create providers independent of the surgical team usually attempt to cherry pick 'low risk' procedures. Such models can leave patients dangerously exposed. Some surgical procedures might appear low risk, but they are often only a millimetre or two from a catastrophic disaster.

Surgeons know that to manage even a 'normal' procedure they must be trained for all possible outcomes - from effortless ecstasy to unpredictable tragedy. Others might try to mitigate risk by trying to predict what will be 'normal', but there is always a risk of disaster. Even for recognised substitution such as using midwives rather than obstetricians, the additional risk seems recognised by the insurance industry as midwives are still unable to obtain indemnity cover in the Australian private sector.

So even if patients are adequately informed and prepared to accept an increased risk (however slight), if their provider is unable to obtain adequate indemnity cover it will be the patient, not the provider, who will suffer both the adverse event and the lack of financial compensation.

Service substitution independent of the surgical team might be appropriate in a developing country where it's that service or none, but such substitution in Australia would still be provided in a framework of first world compensation with hair trigger litigation and multimillion dollar payouts.

Health Workforce Planning – Setting Workforce Numbers

Workforce numbers and the distribution of Basic Training Positions have become such a political football that it seems useless to apply logic in determining how many surgeons are needed and where they should be trained. The Productivity Commission acknowledges in its Issues Paper that "health w**orkforce planning is intrinsically imprecise" ((**

These solutions have the added benefit that they could be put in place with almost immediate impact and not have the four, 10 or 16 year lag time to turn medical practitioners who have passed their BST, new medical graduates or first year medical students into independently practicing surgeons who would in any case still be faced with the same inefficient public hospital system.

It angers surgeons when they are blamed for long public hospital waiting lists when the real reasons, lack of efficiencies and funding, are not being addressed.

There is an urgent need to address non-workforce solutions to improving the efficient delivery of surgical services in the public hospital system and this should take priority over any other activity designed to improve the productivity of surgical services.

Rural Workforce Issues

All healthcare workers, including surgeons, are less represented as a percentage of the population in rural and regional Australia than they are in the cities. The problems here are not so much one of productivity, but as the Commission's Issues Paper points out – "Some 'lifestyle' and 'nature of work' considerations that make it hard to attract health professionals to rural and remote areas may be very difficult or even impossible to overcome through changes in policy."

The question here might be more fairly represented as how do we most efficiently ensure Australians living in remote, rural and regional Australia have access to timely, effective and affordable surgical services.

As has been outlined above, surgical services require much more than just the presence of a surgeon. The infrastructure requirements are an insurmountable barrier to providing services to all but the largest remote centres such as Mt Isa and Broken Hill. For the rest of remote Australia, initial acute surgical care (and even some elective surgery) is provided either in their communities by suitably trained general practitioners, by fly-in services such as the Royal Australian Flying Doctor Service, or else the patient is transferred to a larger centre by private transport or by one of the road or air based ambulance services.

The greater specialisation of the surgical workforce only compounds the difficulty of maintaining a sustainable rural and regional surgical service. For example, an orthopaedic surgeon who specialises in the shoulder may not be as expert on general trauma surgery. Similarly, a general surgeon in rural practice needs to have a wide range of expertise to meet the needs of the community. Training programs for surgeons wishing to practise in the country need to be geared to provide this diversity and that can be difficult to achieve.

Most Australians want health services provided as close as possible to where they live. Rural surgeons indicate that is true for surgical services as much as it is for any other health service. Even if informed there is a slightly greater risk of an adverse outcome, many rural patients still prefer to be treated close to home.

The major reason general practitioners give for leaving or not entering rural and remote practice is the demand for being on call after hours[9]. It is likely surgeons are no different. So apart from the infrastructure demands, unless two or three surgeons can work together in an after hours roster, such services might not get started or if they do, even the loss of one surgeon from a roster in a multi-surgeon practice can have a knock on effect where all the surgeons might leave.

Even then some services, which because of their technical nature require a modern tertiary hospital (e.g. neurosurgery, cardiothoracic surgery) or need high population levels for adequate demand (e.g. paediatric surgery), will be difficult to establish in even regional settings.

However, robust models for sustainable regional surgical services need to be developed for general surgery, orthopaedics, ENT, ophthalmology, gynaecology and urology. Some of these services might be provided as outreach or, and this is the least preferred for quality patient care, by fly-in/fly-out services where a specialist surgeon and perhaps anaesthetist and other theatre staff arrive, deliver the service and leave, with shared aftercare provided by a more general surgeon, resident GP or other appropriate team member. Where small regional and rural hospitals are being closed down and theatres are subsequently lost, one option is to provide a complete mobile theatre and staff as is the case in New Zealand in a specially fitted bus that moves from area to area.

Telemedicine, used now to provide Medicare rebateable consultations to rural and remote areas for psychiatry, does have the ability to improve the delivery of surgical services. Telemedicine can allow a trained surgeon to provide advice to the patient or healthcare provider in a place remote from where they are based. This could include guiding a less skilled colleague or GP through a technically difficult or emergency operation. However, the prospect of surgeons being able to operate remote robotic surgical services via telemedicine as a way to provide the majority of surgical services to under serviced areas seems unlikely in the timeframe considered by the Commission for this study. Even then, such activity is likely to demand the full-time concentration of a fully trained surgeon and not result in the delivery of more surgical services to the whole community even if it results in more services to rural and regional communities.

The rural surgical workforce is ageing like the rest of Australia's health workforce, which will compound workforce problems[10]. Current dissatisfaction with local health services and their emphasis on budgetary constraints is leading to many experienced surgeons taking the option of retirement earlier than they would otherwise do so. This is to the detriment of service provision to the community, which may have great difficulty recruiting replacements. Health services need to be sensitive to this and willing to address the concerns of their surgeons, often with decades of knowledge of a community, so as to retain as much expertise as possible, perhaps by offering alternative attractive methods of employment.

If services cannot be provided within the community then rapid, reliable and affordable patient transfer systems need to be established for the patient and, in most cases, for relatives or guardians.

Overseas Trained Doctors

In a period of workforce shortage Australia has become increasing reliant on overseas-trained surgeons to fill the gaps, with some regional public hospitals now entirely dependent on OTDs in order to provide surgical services to their communities. Before entering surgical practice in Australia OTDs pass through an assessment process, which plays an important role in helping to maintain the safety and quality of surgical services. However, as assessment requirements determine whether overseas-trained surgeons can enter the workforce or not, if the requirements are too stringent this could affect community access to surgical services. Getting this balance right can be a difficult task.

In 2000 the RACS sought to test whether it had that balance right when it sought authorisation from the ACCC in relation to assessing the qualifications of overseas-trained practitioners. The ACCC in its Final Determination in respect of that application required that the College establish an independent public review of the test for assessing overseas-trained surgeons[11]. The overall aim of the review was to identify the minimum requirements that overseas-trained surgeons should be expected to meet before being permitted to practice in Australia.

The Review Committee recommended principles upon which the assessment process should be based. The process should:

- ensure that surgeons are competent for the relevant scope of practice,
- enable competent surgeons to practice where they are needed,
- be fair, transparent, objective and valid, simple and easy to navigate, speedy and efficient, and
- involve College, jurisdictional and consumer representatives.

The RACS at its Council meeting on June 2005 accepted all the recommendations of the review committee.

However those processes can only work if they are used. The RACS was not involved in the assessment of Dr Jayant Patel and alternate processes were used in Queensland. Sometimes jurisdictions are desperate for a surgeon, sometimes just any surgeon. There need to be checks on OTDs and they need to assess not just their qualifications, but any adverse incidents in their past work history.

Not all OTDs, despite what their paper qualifications might be, are competent for the scope of practice in which they are placed. The funding model for public hospitals in Queensland, which had financial inducements and targets for more complex surgery, was at least one factor that seems to have led to complex surgery being undertaken in Bundaberg that would usually only be performed in major metropolitan hospitals.

Rural surgical services, more than any other area, suffer from inadequate funding, support structure and equipment to sustain surgery of an appropriate breadth and standard. Consequently, it is only some overseas-trained trained surgeons who will accept jobs that locally trained surgeons recognise to be poorly structured and supported. This can compound some of the quality issues already discussed.

Australia should become completely self-reliant on Australian trained surgeons to provide its surgical services, but while we want for the funding and training places to become available to produce those additional surgeons, we will have an ongoing requirement for OTDs. OTDs need to be properly assessed through a process that is based on the Review Committee's principles. Those principles insist that the RACS (and consumers and jurisdictions) must each have a role. Disasters can occur when the principles are ignored and the process bypasses the RACS.

Solutions

The RACS agrees with the Productivity Commission when in its Issues Paper it makes the observation that:

> "The most fundamental requirement for achieving better workforce outcomes seems clear. It is to create incentives and supporting institutional funding and regulatory arrangements that encourage all parties to work efficiently, effectively and cooperatively to further the interests of patients and the wider community."

The RACS wants to work cooperatively with all parties at national and state levels but their cooperation will mean nothing unless individual surgeons become engaged. The feedback from RACS members is their support will be very difficult to gain because senior opinion leaders, outside of surgery, constantly blame public sector access problems on restrictive work practices by surgeons. Most surgeons work at the coal face and know where the real problems lie. Ill-informed criticism puts at risk the necessary cooperation from individual surgeons who after all cannot be forced to work in the public sector, but must be attracted and retained by incentives and good working conditions, part of which must be changes to make service delivery more efficient.

The RACS also agrees that if there is to be greater cooperation there needs to be greater clarity of objectives. The National Health Workforce Strategic Framework is an important part of obtaining that greater clarity, but the RACS strongly agrees with the Commission's suggestion in the Issues Paper that to strengthen the framework,

> "One possibility would be to put greater emphasis on the need for governments and others to condition the expectations of consumers about what levels of service can realistically be provided in what circumstances and over what timeframes. Unrealistic expectations can be a source of tension and reinforce a policy emphasis on short term rather than long term requirements."

The sooner there is a mature discussion on what can be delivered within the fiscal restraints imposed by funders the sooner there will be an end to the name calling and blaming that are preventing cooperative solutions to efficiency problems.

The RACS is conscious that even defending itself against 'naming and blaming' might incite others to escalate their attacks, but nonetheless unless the right problems are identified it is likely only wrong solutions that will be proposed.

There is an urgent need to address non-workforce solutions to improving the efficient delivery of surgical services in the public hospital system and this should take priority over any other activity designed to improve the productivity of surgical services.

There is an urgent need to fund, as a minimum, an additional 100 Specialist Surgical Training posts.

Summary

Surgeons are

- annoyed that funders are blaming them for long waiting lists when they are the result of a lack of funding,
- concerned that even after a rigorous examination by the ACCC they are still accused of running a 'closed shop',
- frustrated that even though they train pro-bono the next generation of surgeons, at a saving to the public system estimated by the RACS at $250 million a year[12], they are accused of self interest and protecting their private practice incomes.

The RACS agrees with the Productivity Commission that solutions require cooperation, but that cannot happen in a negative climate. Funders and administrators have a lot of work to do before that negativity is dissipated sufficiently to allow a climate of cooperation. The RACS will continue to play its part, but getting the cooperation of individual surgeons requires acknowledgement of the real barriers and problems in individual hospitals, clinics, operating suites and wards.

The RACS believes governments and others should take the Commission's advice and place "…greater emphasis on the need … to condition the expectations of consumers about what levels of service can realistically be provided in what circumstances and over what timeframes", or ongoing tensions will continue to fuel a climate of blame and short-term solutions that attempt to paper over the cracks rather than address the serious underlying problems.

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