Australian
Society of Anaesthetists

Response
by
Australian Society of Anaesthetists
to
Productivity Commission's Review
Draft Position Paper
–
Australia's Health Workforce September 2005

Introduction

The Draft Position Paper has the potential to influence the direction of health services in Australia over the next decade. It is essential that that the Draft is as comprehensive and transparent as possible. However, while it provides many high level general observations and a list of recommendations, it appears to lack the detail necessary to substantiate the key points being presented.

The Australian Society of Anaesthetists (ASA) appreciates the opportunity to contribute to the original paper as well as prepare a response to the Draft. The ASA's response is constrained to four specific issues raised in the Draft:

a. **Scope** - Insufficient information has been provided on the forecast supply and demand of the Australian health workforce.
b. **Safety and Quality** - Quality of healthcare is not addressed when considering alternative provider options.
c. **Detail** - the Draft skirts the major issue of health funding arrangements.
d. **Regional and Remote Workforce Capacity** – a balance of expectations.

Scope of the Draft

Medical Workforce Analysis
The draft was required to address, inter alia, 'supply and demand pressures over the next 10 years'. Unfortunately, there is little in terms of information, interpretation or projection on the likely demand (for services) and hence the supply (of health workers).

It is disappointing that Chapter 9 of the Draft was not developed fully and used as the basis for extrapolating the alternative strategies discussed earlier in the Draft (Chapters 4 and 5).

The ASA position on supply of anaesthetists is contrary to the information reported in the Draft[1]. The Draft indicates that there is a 1.5% shortfall projected in anaesthesia with an increase in required training of 7%. However, medical graduate numbers are already expected to grow by 60% over the next five years with anaesthesia training places limited only by

[1] Box 1 page xxiii.

jurisdictional funding. The ASA believes there is no systemic shortage of anaesthetists rather a maldistribution. The factors affecting the maldistribution are principally economic and lifestyle.

Maintaining Established Relationships

Reducing the health bureaucracy is applauded, however the ASA cautions against demolishing extant arrangements that have grown through mutual need and in which strong working relationships have been established. It is hoped that 'subsuming' the Medical Services Advisory Committee and the Medical Benefits Consultative Committee[2] implies 'amalgamating and rationalising'.

Safety and Quality

The Draft has highlighted a personal view of Prof Duckett including an extract from his Journal, Australia and New Zealand Health Policy, *"In this way, for example, an anaesthetist would be able to bill for the work of a nurse anaesthetist using the anaesthetic items of the Schedule. Assuming salary costs for the substitute professional are lower than the medical specialist, this would then put a financial incentive on medical practitioners to utilise other health professionals for service delivery."*

The Draft continues by discussing the methodology of listing MBS items that do not require 'personal provision' by the medical practitioner. "Personal provision' is assumed to be a medical service for which the risk of an adverse outcome is extremely low? While the section of the Draft continues to discuss the mechanics of delivering medical services by alternative health professionals it make no reference to the quality and safety implications of this practice. A recent study reported in Anesthesiology, the Journal of the American Society of Anesthesiologists, concluded that … "*mortality after surgery is substantial and an association was established between perioperative coma and death and anesthesia management factors like intraoperative presence of anesthesia personnel, administration of drugs intraoperatively and postoperatively, and characteristic of delivered intraoperative and postoperative anesthetics care.*"[3]

Safe anaesthesia is not simply routine sedation; and there is no such thing as 'a simple anaesthetic'. Each patient reacts differently to anaesthetic. The recovery of a patient from an adverse situation needs to occur rapidly and faultlessly. Specialist anaesthetists spend at least 13 years in training to avoid such events. In addition, advances in anaesthesia have enabled dramatic shifts from overnight hospital stays to safe and efficient day surgery, which has had enormous health and productivity benefits for the Australian people.

In those countries with a "British medical heritage" such as the United Kingdom, Australia, New Zealand, Canada, South Africa and the Republic of Ireland, the *medical specialty of anaesthesia* has developed as a *specialty practised by medical practitioners* who have undergone conventional university-based medical teaching and training and early postgraduate experience in general medicine. By contrast, and in marked contradistinction, a very different arrangement has evolved in the United States over the last 90 years, where alternative providers administer anaesthesia under the supervision of medical doctors because there were not, until recently, adequate numbers of anaesthesia providers.

In Australia, anaesthesia is administered to 3.2 million patients (or 16% of the entire population) annually with a safety record not exceeded elsewhere in the world. Most of these anaesthetics are provided by the approximately 2,000 specialist qualified anaesthetists. Some

[2] Page LI

[3] Arbous, M.S, et al, 'Impact of Anesthesia Management Characteristics on Severe Morbidity and Mortality', Anesthesiology, 2005; 102:257-68

5% are provided by general practitioners, many of whom have undertaken the joint training programme of the ANZCA and the Royal Australian College of General Practitioners (RACGP), who practise with appropriate credentialling. Thus all patients who are anaesthetised in Australia have the exclusive and dedicated care of medically qualified anaesthetists. Anaesthesia in Australia is a medical act.

Australia has been analysing the safety of its anaesthesia rigorously for 45 years. No other country has data analysis that is comparable. Since 1960 the numbers of deaths that are associated with anaesthesia errors have halved every 10 years. Today the mortality wholly attributable to anaesthesia is one death per 220,000 anaesthetics. It is similar to the risk of flying. This is in an area of medicine where crises can develop suddenly, at any time, which if not resolved in minutes can result in permanent brain damage or death.

Unlike the United States, where there has been a tradition of alternative anaesthesia providers, surgeons and other proceduralists in Australia do not have the necessary skills in anaesthesia and resuscitation that are required to either direct anaesthesia care or assist in an anaesthetic emergency. As such, if an anaesthesia related complication occurred in Australia without a medically qualified anaesthetist present there may be nobody capable of rectifying it – leading to significant increased risk of morbidity and mortality.

The ASA believes that anaesthesia is a "medical act" that is practised most competently by medical practitioners, with a fundamental part of anaesthesia training being the basic knowledge of medicine attained at medical school and in the first two postgraduate years of general hospital experience. The ASA acknowledges and encourages the current perioperative roles of nurses and technicians in providing much-valued support in anaesthesia, intensive care medicine and pain medicine, and notes the significant national shortage of clinical nurses. The ASA believes that the introduction of "alternate providers" with shorter and likely poorer training programs must compromise the recognised high standard that has been achieved over a significant period of time by a large number of committed anaesthetists.

The ASA strongly recommends that the final Position Paper of the Productivity Commission provides a balanced perspective regarding examples such as the substitution of less well-trained and inexperienced health workers as a means of reducing health expenditure.

A Draft without Detail

The Draft presents broad and high level concepts based on, in the main, frameworks and theories. However, one of the cornerstone Principles of the National Health Workforce Strategic Framework is disputed by the Draft. This is the principle of 'national self-sufficiency in health workforce supply'.[4] It is incongruous that a nation with Australia's economic wealth, education facilities, population size and national presence should not be a net producer of health workers.

This view by the Productivity Commission taints arguments in the Draft and flows through to the recommendations offered to CoAG. Meeting demand through importation of overseas trained health workers has previously been perceived as a short term or expedient solution. The Draft envisages it as a permanent strategy to meet growing demand. Consequently it lessens the pressure on health funding for national training positions. Chapter 8 discusses the funding of medical services at a strategic level without engaging in detail, funding shortfall or recommendations to improve the efficiency of the process.

It appears the Draft is designed as a compromise of States and Federal boundaries. The major factor in health in the future is defining what health services Australia wants and can afford. This fundamental issue has been 'written out' in the Draft.

[4] Box 3.2 and pages 33 and 34.

Regional and Remote Workforce Capacity

While the ASA supports the initiatives proposed in Chapter 10 of the Draft to encourage a greater medical workforce presence in regional and remote areas of Australia, The ASA cautions against a 'one hat fits all' approach. The AMA's concerns over the quality of the workforce that might be attracted to the less popular regions[5] is supported, however the ASA is equally concerned with creating expectations of services that are patently unviable due to the infrequency of specialised procedures. For example, in the USA patients are willing to travel large distances to attend centres of excellence, contrary to the Australian concept of provision of facilities 'at their back door'.

Australia is not able to provide the highest quality healthcare within each local community. It is simply too expensive and impractical to provide immediate local access to tertiary and high level secondary healthcare to every member of the community in their local community environment. A far higher standard of health care is delivered if surgery and anaesthesia is consolidated into large centres. This permits all members of the health delivery team to maintain and improve their skills due to the combination of collegiate support, enhanced medical infrastructure and the high volume of services being provided.

Large centres for surgery and anaesthesia also enable far better continuing education of the staff, more reasonable rosters (one in five rather than one in one, for example) and opportunities for leave/rest to be taken. This leads to a greatly increased ability to attract and retain anaesthetists.

Conclusion

The Draft Position Paper has brought together the numerous disparate concepts for Australia's future medical workforce requirements. The ASA appreciates the opportunity to contribute to this review. The Society's major concerns regarding the Draft are that it lacks appropriate detail (that, as a minimum, should be included as a supporting document) and that it suggests, without providing any corroborating evidence, that alternative health workers can carry anaesthesia out 'safely'.

[5] Page 169