AUSTRALIAN ORTHOPAEDIC ASSOCIATION

# A Response to the Productivity Commission Position Paper, "Australia's Health Workforce", by the Australian Orthopaedic Association

## Preamble

The AOA has a deep interest in the proposals contained in the Productivity Commission report and the policies that may emanate from them. It believes that the current process is an opportunity for the whole community to achieve an understanding of the way in which health care is delivered in this country, and, through that understanding, to improve it.

The primary mission of the Australian Orthopaedic Association (AOA) is to provide programmes of higher specialist training in orthopaedic surgery and continuing professional development to its members. Its Fellows and Associates are totally committed to maintaining and improving the musculo-skeletal health of the Australian community.

The AOA works in conjunction with the Royal Australasian College of Surgeons in matters of training and education and is party to its representations in this matter. It does, however, reserve the right to put its submissions and opinions directly to the Productivity Commission, or any other agency, if it considers that the views of the AOA are not being put with sufficient force.

The AOA response to the Productivity Commission Position Paper, "Australia's Health Workforce" is divided into the following sections:

1. General Overview,
2. Training Issues,
3. Workforce Issues,
4. The Maintenance of Professional Standards, and
5. The Need to Review the Impact of Health Administration in relation to items 2-4 above.

## General Overview of the Productivity Commission Position Paper, "Australia's Health Workforce"

The Productivity Commission's position paper represents an attempt to produce a global overview of the Health Services in Australia with specific reference to the health workforce. The intended objectives of the proposals contained in the paper are to ensure the delivery of quality health care over the next 10 years. Problems which have been identified with the current health care system by the Commission include:

1. A shortage of professional personnel
2. The mal-distribution of professional personnel
3. The impact of population ageing
4. Poor utilisation of the workforce
5. Potentially inadequate or unresponsive educational systems
6. Disparate registration and accreditation standards and processes
7. Inadequate use of the MBS payments schedule to produce desired outcomes

There are several aspects of the Productivity Commission position that the AOA supports and other suggestions that we believe have the potential for harmonious development. We have found, however, that the position paper as a whole tends to be repetitive and full of obscurantist jargon. This is regrettable, as it is the belief of the AOA that an open and transparent process, which is easily understood, is in the interests of the whole community.

One of the major concerns with the paper as a whole is the lack of any costing of the proposals being considered. It is not possible to evaluate proposals that may well be completely impractical because of the costs that certain schemes would generate. This is especially pertinent to the idea of either the Federal or State Governments assuming control of higher specialist training. The AOA is aware that the cost of the development of a higher surgical training curriculum, of achieving AMC accreditation, developing standards and quality assurance procedures, paying surgical educators and administrators, carrying out a fair selection process, accrediting training posts, developing an examination system, examining candidates and providing them with an internationally recognised qualification would be extremely high. Such expenditure must then be balanced against any potential improvement (or deterioration) in the final outcome. Canvassing such options without providing an accurate estimate of costs is, in the opinion of the AOA, irresponsible.

The AOA also finds it surprising that, in this document, there is no discussion of the impact of the increase in administration and bureaucratic processes on the standard of health care delivery in this country. Indeed, there is not even any clear acknowledgement of the existence of this body of workers or the effectiveness of their roles. In statistics presented in Fig 2 and Table 1 (pp. *xx* and *xxi* of the summary section), the bureaucracy is not mentioned as contributing to health personnel. Their numbers are probably hidden in a group designated as 'Other', which represents 15% of all personnel and has grown between 1996 and 2001 by 30.2%! One cannot help but wonder if the growth in this sector, and the costs involved in supporting this growth, are correlated with the service downturn at the coalface. Some discussion of this factor is required if the report is to have any credence within the general community.

The unacknowledged growth of health service administration is causally related to the issue of the diminution of the role of the medical profession in health care decision-making, and this topic has also been completely overlooked. One cannot stress enough the need to have medical professionals as the primary decision-makers with administrators serving the purpose of assisting with the implementation of the decisions. There is clear evidence[1] that the growth of the administrative sector has been one of the major factors responsible for the progressive decline of the National Health System in the United Kingdom.

[1] Extensive references provided in "Hippocratic Oaths", by Raymond Tallis, Atlantic Books, London, ISBN 1-84354-126-2

The position paper also meticulously avoids a series of pressing, but politically sensitive, issues. The political matters that are, in the opinion of the AOA, either avoided or inadequately treated are:

- The issues which are specific to women in the workforce. The rising proportion of women in the surgical specialties and the effect of this on the workforce are ignored. The poor retention of female nurses in a climate in which service is considered demeaning is not mentioned.
- The potential for a division of responsibility between the public and private health care systems.
- The changing nature of social expectation to health and activity. Some issues here are touched on obliquely, e.g., the impact of technological advance and that of ageing, but these are presented simply as realities, rather than as issues to be managed.
- The relationships between Federal and State governments in the delivery of health care.

**Workforce Issues**

The Australian Orthopaedic Association is committed to training, and maintaining, a sustainable orthopaedic workforce for the Australian population. This workforce needs to be deployed in the public and private sectors and needs to be highly qualified with skills in general orthopaedics, orthopaedic trauma and speciality orthopaedic practice. For continuing productivity in the workforce, surgeons need to be involved in appropriate on-call arrangements and be adequately funded to provide the whole range of orthopaedic services.

The AOA recognises that there are significant problems in recruitment to certain subspecialty orthopaedic disciplines. Currently, it is increasingly difficult to entice orthopaedic surgeons into the disciplines of paediatric orthopaedics, spinal surgery and trauma. The reasons differ and each discipline needs different solutions. The AOA offers its services to the Commission in resolving these issues.

For long-term productivity, the Australian Orthopaedic Association believes that a surgeon should have a working and lifestyle environment that allows him/her to be productive in orthopaedics for a long period. Factors which undermine the maintenance of a highly qualified and contented workforce include current medical negligence law, the associated cost of insurance premiums, inadequate infrastructure support, lack of adequate theatre time, inadequate equipment and a restriction on the range of procedures which can be performed. The Australian Orthopaedic Association has produced a document entitled "Fundamental Requirements for the Practice of Orthopaedic Surgery" that may be taken as the basis of sustainable orthopaedic delivery in the community.

The AOA recognises that orthopaedic manpower problems in Australia occur in three guises:

1. Under-utilisation and inefficient utilisation of the current workforce,
2. Mal-distribution of the workforce, and
3. An insufficient number of qualified surgeons

The AOA supports the National Health Workforce strategic framework goals and, in particular those of:

- having a workplace environment in which people
    - want to work,
    - can make optimal use of their skills, and

- having a workforce with,
    - appropriate skills, and
    - adaptability.

The AOA believes that workforce innovation is capable of delivering efficiencies and responding to community requirements. It firmly believes, however, that **all reappraisals should start with a clinician-based approach to the delivery of surgical services**. Initiatives which are primarily motivated by political or economic considerations are unlikely to find favour, either with the medical community or with the wider Australian public. Furthermore, they are unlikely to provide a workable and sustainable solution to any workforce problems.

The AOA notes that there is a great difference between the efficiency of delivery of certain services between the public and private systems. High quality, fully accredited, private hospitals are capable of delivering many services at lower cost, with greater reliability and with equivalent or better outcomes.

The AOA recognises that there is mal-distribution of specialist orthopaedic services but wishes to emphasise that many of the mal-distribution problems are the product of strong professional disincentives which are built into many hospital posts. A well-trained orthopaedic surgeon will only be attracted to a post if that post provides a rewarding professional life and a reasonable remuneration.

The fact that various social support systems and services have been steadily declining in non-metropolitan areas over the past two decades is also a strong disincentive for specialist surgeons to move to outer-metropolitan or rural regions.

**RECOMMENDATIONS**

#1. That the recruitment problems of the sub-specialist disciplines of paediatric surgery, spinal surgery and trauma be examined and measures taken to alleviate them as a matter or urgency.

#2. That the provision of orthopaedic surgery (which includes musculo-skeletal trauma) in a hospital setting should follow a basic template which comprises, at its minimum, an 'Orthopaedic Hub' of three or four orthopaedic surgeons who work in a single co-operative orthopaedic unit to deliver both private and public care to the local community.

#3. That hospitals that have difficulty in recruiting orthopaedic staff be subject to a full review before any stop-gap arrangements, such as a declaration of an area of need, are made. Where the problem is the recruitment of orthopaedic specialists, the review process should include personnel from the AOA.

#4. That the efficiencies of delivery of certain services, by the private hospital system, be carried over into the public system.

**Higher Surgical Training**

The Australian Orthopaedic Association, acting as an agent of the Royal Australasian College of Surgeons, has established a world-class training programme in orthopaedic surgery which is widely regarded as the current gold standard. This programme has provided high quality and skilled orthopaedic surgeons for the community of Australia over several decades. It is therefore of the utmost importance to introduce radical change with great care. **It is vital**

**that training programmes overseas which have not delivered the quality outcomes of the Australian system are not looked upon as examples to be followed.** The Association maintains that the Australian orthopaedic training produces orthopaedic surgeons of an equivalent or higher standard than those of the UK, USA or Canada.

A similar warning extends to the examples of disappointing initiatives within Australia itself. Two decades ago, the transfer of nursing training to the university sector was promulgated as the solution to the crisis in nursing manpower. The results of the initiative have been unsatisfactory and the changes introduced may have made the situation worse.

The strengths of the current higher surgical training system are:

1. It concurs with the standards set by the Australian Medical Council and the ACCC
2. It is a national scheme, with a uniformity of standards across the whole country
3. It is recognised internationally as being of the highest standard
4. It is administered by practitioners of the art and science of the specialty, who have direct clinical contact and who are sensitive to the needs of their patients
5. It is responsive to educational and social imperatives, and
6. It is highly cost effective.

The Australian Orthopaedic Association does recognise significant challenges to the delivery of higher surgical training and wishes to co-operate with the Productivity Commission and other government agencies in dealing with them. Specifically, these include:

1. The inability of Public Hospitals to provide comprehensive exposure to some clinical material for its trainees. This is especially marked in elective orthopaedic surgery.
2. The difficulty that the Public Hospitals have in retaining consultant surgeons in a number of different scenarios.
3. The increasing difficulty of supervising and teaching trainees using a consultant body which is providing '*pro bono'* work in an unconducive public hospital environment.
4. The tendency of State Governments to under-fund and under-resource registrar posts leading to a shortage of suitable higher surgical training positions.

**RECOMMENDATIONS**

#5. That a single national system of higher surgical training in orthopaedic surgery be maintained.

#6. That the State Governments improve funding to a level that would permit the Royal Australasian College of Surgeons to increase the number of higher surgical training posts.

#7. That appropriate incentives be provided for supervisors of higher surgical trainees. This should include selective use of fee for service and differential MBS payments.

#8. That higher surgical training be extended further into the private system.

## The Maintenance of Professional Standards

The Australian Orthopaedic Association provides a vibrant and extensive programme of continuing professional development through its educational activities. These include:

1. an annual scientific meeting
2. regular (bi-annual) continuing education meetings,
3. data collection of evidence of continuing education,
4. support for research activity of its members, and
5. information and advise in response to member demand.

These activities are both national and international in character and reflect worldwide trends in professional education. These activities are supported by a mix of employed personnel (paid for from membership subscriptions), industry, and 'pro bono' work of AOA members. The AOA is therefore well positioned to accept responsibility for both the provision of continuing professional education, the monitoring of the standards of their members and for the accreditation of their members in this respect.

The Australian Orthopaedic Association agrees with the Productivity Commission's position on the issue of a single national registration body. It also believes that this concept should be extended to the acceptance of a single national accreditation body with responsibility for the accreditation of higher surgical training and the accreditation of the continuing maintenance of professional standards through an appropriate programme of continuing professional development.

RECOMMENDATIONS

#9. That the Australian Orthopaedic Association remain the principle provider of specialist orthopaedic educational activity required for continuing professional development.

#10. That the Australian Orthopaedic Association be the sole accreditation agency for orthopaedic ongoing professional development.

## Administration

The inquiries in Queensland into the administration and running of Bundaberg Hospital and into the Harvey Bay Hospital have highlighted the deficiencies of that state's administration processes. It has identified a top-heavy, unresponsive and opaque bureaucracy, which has cost the State millions of dollars. Administrative problems, however, are not limited to the State of Queensland. In the last two decades, Western Australia has had countless re-organisations of its health services, undertaken at enormous cost and with negative outcomes for the delivery of clinical services. The West Australian government is in the process of yet another reorganisation. In New South Wales there have also been difficulties associated with the role of the administration in the delivery of health services.

The constant high level of growth of the administrative sector in the face of more or less static delivery of clinical services needs to be investigated and reversed.

A system of performance benchmarking of administrators in terms of the effectiveness and efficiency of clinical services should be introduced.

The persistent use of area of need appointments in areas in which there is no shortage of locally trained surgeons indicates a dysfunctional interface between the jurisdictions and the medical community which must be remedied.

**RECOMMENDATIONS**

#11. That the role of health care administration at all levels, its practices and philosophies be subject to public scrutiny and independent review to the same extent as all other contributors to the health care system in Australia.

#12. That the growth of the administrative sector be reversed and the resources which are saved be redirected into patient care.

#13. That area of need appointments are not made until an independent panel, which includes representatives of the specialty in which the appointments are being considered, has reviewed the circumstances of the proposed appointment.

**SUMMARY**

The Australian Orthopaedic Association supports the concept of a wide-ranging review of the Australian Health Care System. However, it believes strongly that the review should be much wider than is currently covered by the position paper. Fundamentally important issues have been neglected and need to be included.

In relation to orthopaedic surgery a series of recommendations is made which, if implemented, would maintain the current high standards of the orthopaedic training and clinical care delivery, and would increase the numbers of well trained surgeons in both metropolitan and rural areas.

**JERZY M SIKORSKI**, President

On behalf of the
Australian Orthopaedic Association

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