ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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Mr. Ian Gibbs
Assistant Commissioner
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P.O. Box 80
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Dear Mr. Gibbs

Re: Response to the Australian Government Productivity Commission Position Paper on Australia's Health Workforce

The Productivity Commissioners are to be congratulated on producing what I would regard as a good initial examination of the problems relating to the health workforce in Australia. However, I think the Commission's recommendations and conclusions have fallen far short of what is required. I think that we would all recognise that for the commission to undertake a study of this magnitude it is extraordinarily difficult and, furthermore, I think it is very difficult for persons outside of the health system to fully comprehend or understand the pressures and problems the workforce is currently experiencing. This is made, even more difficult by the fact that there are very major regional differences in the way the workforce works and functions within Australia. This reflects the diversity of our country, the sparsity of its population and the needs of our indigenous people. I recognise that this inquiry was never designed to be an inquiry into the entire health system and yet without an inquiry into the health system it is hard to see how we can make any real progress. One has to also wonder whether the Treasurer really desired a truthful and accurate description of the problems which are current and which are developing within Australia's Health Workforce.

In my view Australia's Health System is currently in crisis. There are enormous inefficiencies within the system and the pressures on the health system are bound to increase. As the Commission has rightly pointed out, this relates to the rapid aging of the population, the chronicity of disease, changes in disease patterns and the cost of the system. Within my own specialty of surgery there have been enormous changes within the last 20 years in our ability to successfully treat older and sicker patients efficiently and effectively. The development in many surgical techniques and the decline in hospital stays have been truly outstanding over the last 20 years. However, this is unlikely to continue as we are starting to see the increasing difficulties of treating older sicker patients with more complex diseases. And yet, the community will demand that we continue to do this to the best of our abilities and of course this is our obligation. Unfortunately it does mean that the improvements in care and techniques will not translate into cost savings over the next 20 years. In my view, the greatest challenge facing Western countries around the world is how to deal with this aging population who will demand greater access and better results from their Health Systems. No country has the answer, but it is instructive never-the-less to look around the world at other systems.

There is no doubt that Australia, as a percentage of GDP, does not spend excessively on its health system. It is much less than in the United States, but there are significant problems with the way the United States Health System works. One of these problems is the enormous expense, and the second problem is the approximately 30% of the population, who have no health coverage. This is clearly not a situation that we would desire in Australia. Alternatively, we have the National Health Service in the United Kingdom which has undergone enormous structural reforms over the last 10 to 15 years. It is worthwhile to read the literature on these structural reforms as they are interesting in some of the concepts that are espoused. Yet despite the enormous increase in healthcare spending, we still see a system which is essentially inefficient, ill-geared to the needs of its population, and unable to react with the flexibility required to confront the problems of the 21st century. In my view, Australia has always maintained a path between these two extremes which has been extremely successful. A mixed Private and Public System has worked efficiently and hopefully will continue to do so. However, unless we make significant changes to the way that the workforce is able to deliver services over the next 10 to 20 years, our health system will become increasing expensive, inefficient and ineffective. I believe that there is no other greater need facing our country, then the need to adequately plan how we are to deal with this challenge, and yet we are confronted by a system which is currently in crisis and not equipped to deal with this challenge.

Although there has been an increase in the number of medical professionals working in the Australian Healthcare System over the last 10 years this has occurred despite the fact that there has been no real increase in the number of medical school places in Australia until recently. This reflects the poor planning that went on prior to this, the inability and inaction of the universities to accurately predict these problems and, of course, the financial pressures on the universities which will cause them to take more and more fee paying students from overseas. This is clearly not a situation that can continue. This has been further complicated by the fact that there has been a general decline in the standard and quality of our universities and in fact I believe that there is only one medical school ranked in the top 100 in the world, which is the University of Melbourne. The shortfall in medical professionals has of course been supported by an increase in overseas trained doctors. This is not necessarily a bad thing and we obviously need to understand that the health workforce is now a global marketplace. Many well trained Australian Surgeons have spent their entire careers in North America or Europe because of greater opportunities. We need to understand that we will be competing on an international basis for the services of highly trained professionals whatever their speciality. There is no doubt that it will become increasingly more difficult to attract overseas trained doctors to Australia and we are already starting to see this pressure in that it is becoming very difficult to attract well trained European and North American Doctors and indeed South African Doctors to positions in Australia. I think the concept of self-sufficiency in our own numbers is a minimum concept that should be pursued. Furthermore there are difficulties in terms of assimilation of overseas trained doctors. The recent events in Queensland, where an overseas trained doctor's credentials were not appropriately checked and where an employing authority, and indeed the Queensland Government, did not request appropriate vetting of this Surgeon's credentials by the Royal Australasian College of Surgeons led to tragic consequences. It is my understanding, that there were a number of well trained Australian Surgeons who decided they did not wish to work in Bundaberg Hospital because of the way the Hospital was administered. Clearly this is a lamentable situation where well trained professionals choose not to work in a system in which they have no faith or confidence. One can not underestimate the effects that these sorts of problems can have nationally.

The Commission has in many ways shied away from the really difficult questions. There is a vague suggestion that credentialing should be a national process. Certainly for medical practitioners, I think that most people would view this as a long overdue reform which would hopefully improve the efficiency of the system of credentialing of medical practitioners wherever they were trained. I think at minimum there should be a national medical registration body to register Doctors. I do not know enough about allied health professionals and nursing to make this suggestion, but one would suspect that there would probably is a case for rationalisation here. The Commission has also shied away from probably the major issue. As it has rightly pointed out Australia's Health System is a bewildering array of interlocking responsibilities, funding authorities and competing interests. In my view, the politicisation of Health over the last 15 years has been a catastrophe and the reluctance of any Federal Government to clearly sort out responsibility for funding so that there is no overlap of government is lamentable, and in my view, indefensible. The inefficiencies that we currently see are in many ways due to a lack of planning and a failure of the political process. There is no national planning authority for delivery of healthcare services. Healthcare services are essentially a political football which is kicked around at election time whether it be state or federal elections. Unless there is a coherent policy of health workforce planning and healthcare service delivery planning which transcends the bickering between all of these competing government and organisations then little reform will be possible. Clearly there would need to be a debate as to what responsibilities Federal and State Governments have in the provision of healthcare services, but it is long overdue that there be such a debate and there be some proper planning which can be done by professionals who are not necessarily subject to the politicisation of the process and the inherent inefficiencies and dishonesty of the political process. In my view, the lack of transparency and accountability in the spending of tax payer's money in the health service is immoral. In New South Wales the budget for healthcare services is now close to $13 billion, and yet we have system which is increasingly inefficient and unable to cope with the demands on it. I realise that this issue is outside of the Commission's terms of references but it is impossible to look at the health workforce issues independently of these issues. In my view, the Commission's first recommendation should have been the creation of a national healthcare delivery commission which is independent and which has real power to influence the way that healthcare is delivered in Australia. It is inevitable that we are going to see an increase in the amount of money spent on health services in Australia and it is essential that this increase be well spent with appropriate safe guards and accountability so that productivity is maximised.

I would like to now comment on the specific proposals which the Commission has made.

1) Draft Proposal 3.1

There is no doubt that there needs to be a national health workforce strategic framework adopted by the Council of Australian Governments and this should be done as soon as possible. All of the other bureaucracies should be rationalised or abolished. There is no doubt that within the context of health workforce planning over the last 10 years current bureaucracies have not really produced the results that we desire or need. Throughout Australia there has been an explosion in the number of bureaucrats in the healthcare system with almost no demonstrable improvement in the quality of the healthcare. The other great challenge facing the health workforce in the 21st century is the provision of safe management. As the Commission would know there is a lot of concern about the safety aspects of providing healthcare for patients in all healthcare systems all around the world. This has not been helped in any way whatsoever by the increase in bureaucracy that we have seen at all levels and indeed all this has done is hampered, in many ways, the workforce who are attempting to provide safe treatment at the coal face. Clearly there should be regular reviews of this process and I agree with draft proposal 3.2.

2) Draft Proposal 4.1

Can only be successful if there is a coordinated approach to workforce throughout Australia. Again this involves agreement between State and Federal Governments as to whom is responsible for what and how it should be implemented.

3) Draft Proposal 5.1, 5.2 and 5.3

Clearly there needs to be reform of training of healthcare workers. The Commission has also not addressed the issue of whether nursing training needs to be a University based course. In New South Wales where we have been examining our own workforce problems, we have looked very carefully at the issue of perhaps having more enrolled nurses who are less highly trained than registered nurses. There may be significant economic and workforce advantages in this approach and I think that there needs to be a significant examination of the efficiency of the university training program in all professions, I believe there needs to be a plan, so that Australian universities truly are world class rather than second rate vocational colleges.

4) Draft Proposal 6.1

Clearly there should be a national accreditation agency for Doctors and probably other healthcare workers. There would be opportunity for significant efficiencies with this approach.

5) Draft Proposal 6.2

As part of this national accreditation body, it could be the body primarily responsible for assessing overseas trained doctors. This would have to be done in conjunction with the various colleges and may in fact streamline the process and make it less onerous for the overseas trained doctors many of whom have family reasons for being in Australia, and more transparent for the community.

6) Draft Proposal 7.1, 7.2 and 7.3

Clearly this should all be rationalised under a national accreditation agency.

7) Draft Proposal 8.1

I do not believe the Commission has given adequate information as to what it actually intends with reorganisation of the MBF schedule. Within my own specialty of surgery we have in New South Wales examined a number of workforce issues which the Commission has not really had the time to do. For example, particularly in rural Australia we think there needs to be an increase in nurse practitioners. These nurse practitioners could be attached to local hospitals or preferably to groups of Doctors and would work in conjunction with them. The idea of providing an MBF schedule fee which is less than what the medical fee is seems to me to be a very good idea. There is also enormous scope for having a separate vocational training programme for surgical assistants and possibly anaesthetic technicians. For example, medical practices or hospitals could employ technicians who could act as surgical assistants and this could perhaps attract an MBF fee. There is a system of surgical assistant training in the United Kingdom and also in North America which seems to work reasonably well. It would probably be better not to use nurses by and large as they are probably the group in the health workforce who are most in demand. I think that there are enormous opportunities under draft proposal 8.1 to plan the health workforce over the next 10 to 20 years to make it more efficient. I do not believe that the Commission had the time or the inclination to appropriately explore this.

8) Draft Proposal 8.2

I think is broadly reasonable. However, the issue which the Commission has not addressed is the issue of varying the MBF rebate system for medical practitioners. For example, there is a very strong argument for paying a higher amount in country areas to attract practitioners there. From my point of view as a surgeon, the MBF schedule fee also severely and inappropriately undervalues our services. This is an issue which will have to be addressed in a productive way.

9) Draft Proposal 9.1

I could not agree more that the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee should be abolished. Their performance over the last 10 years has been lamentable. In my own specialty of surgery their projects of workforce needs have been totally inadequate and out of touch with what was required.

10) Draft Proposal 9.2

Again in my view, unfortunately it sounds like it is just creating another bureaucracy without any real end points. Possibly the commission could elaborate on this proposal.

11) Draft Proposal 10.1

There is no doubt that the problems of providing appropriate healthcare services in rural areas and to Indigenous People are enormous. These problems are particularly acute in Australia compared to most other Western countries and require imaginative solutions which we have not seen to date. There are many parts of rural Australia where healthcare services provided are no better than Third World Countries. This is something which we as a community must address as a matter of some urgency. The Government needs to look at the issues of decentralisation so that country towns can be viable so that they can support highly trained professionals whether they be in healthcare or other professions. Unless this is done, it will continue to be a very difficult problem. We must look at providing higher payments for healthcare professionals who work in very remote areas and we must look at better transport systems and hubbing of services so that they can be efficiently provided to patients. In a country such as ours it is unlikely, and indeed not necessarily desirable, that all citizens will be able to access services close to where they live. There needs to be a realisation by the population and this is not only in rural areas but some services must be hubbed and there will have to be good transport arrangement so that patients can be taken to these hubs.

As I have stated this problem does not just apply to remote areas. Within metropolitan Sydney the provision of surgical services is an appalling hotch potch of inappropriate planning which does not provide good surgical services in the way that they should be in the 21st Century. There will need to be rationalisation of Emergency Departments. As the Commission quite rightly points out, Emergency Departments all around the country are inundated with patients who could be appropriately treated in General Practice Units. In my own hospital, the concept of having a General Practice Unit within the Casualty Department was trialled some years ago and was an unmitigated disaster.

However, I think the concept of providing incentives for groups of GPs to set up offices close to hospitals is a good idea. I think with adequate planning this could significantly improve the efficiency of the system with little cost.

There is also scope for major metropolitan teaching hospitals to accept responsibility for providing healthcare services in rural areas. This use to work reasonably well but at least in New South Wales, it no longer does. There are ways that specialists could be rotated to rural areas, could spend short time in rural areas and there are many imaginative ways that we can deal with this problem.

12) Draft Proposal 10.3

Is covered by most of what I have said but it does require an imaginative approach and if we have more semi informed bureaucracy in the process it will fail as it has over the last 20 years.

13) Draft Proposal 11.1

I think is quite clear.

There are a number of other issues which the Commission has only just touched on which are absolutely essential if one is to plan an appropriate healthcare workforce over the next 20 years. There has been reference to the lack of job satisfaction particularly within in the Public Sector in Australia. One can not exaggerate how important this is and how critical it is to change this. Within my own hospital, morale has by and large collapsed over the last 10 years and this is mirrored in the inefficiency that we see frequently within the system. As you would know from one of your submissions there are many, some say as many as 30 000, nurses in New South Wales who choose not to work in their profession. This is for a variety of reasons and often relates to the inability to secure childcare, outmoded bureaucracy and hierarchies within the nursing profession and a lack of a career path for those nurses who wish to provide clinical services and not become administrators. This is an issue which I hear repeatedly from nurses. There are also other mundane issues such as the fact that parking is not often provided. In my own hospital, the nurses often have to walk late at night to the back of the car park with some considerable danger and no real protection. Additionally, they are then charged for this car parking which may or may not be available. This is clearly unacceptable and the Public Sector has to become a workforce friendly environment so that people wish to be part of it. These problems do not just apply to nurses. Amongst Surgeons, the overwhelming desire is that they can retire and leave the system as soon as possible. Most Surgeons plan to retire by 60 years of age and many would retire much earlier if they could afford it. This is something which has changed dramatically within a very short period of time. There is also the issue that many Surgeons no longer find it desirable, financially viable, intellectually stimulating, or rewarding in any way to work within the Public Hospital System. This is a catastrophe that has occurred over a very short period of time and must be reversed. A lot of this relates to the explosion of the bureaucracy within the Public Sector and their lack of understanding of the issues which all workers face within the workplace. It is imperative that if Australia is to provide adequate healthcare workforces at least within the broad speciality of surgery that surgeons desire to work within the Public Sector. There is also enormous ability to use older Surgeons and indeed older Doctors and nurses in more productive and imaginative ways. This is not occurring at the current time and is only exacerbating the problem. In my view there are numerous ways that nursing practitioners and doctors can be used in slightly unusual working arrangements which could help to support the system. None of this has been addressed.

The other major omission which I think the Commission has made in its report is its lack of examination of the issues of funding. There is almost no examination of the synergistic role that public and private hospitals and indeed public and private bodies can make to the efficient working of the healthcare workforce and subsequently the healthcare system. Although it probably wasn't within the gamut of the Commissions terms of reference, there are clearly major issues with the way that patients pay for their healthcare. In my view the Public Sector is going to have to focus on core responsibilities and do this efficiently and extremely well with an appropriate workforce. It is clearly inappropriate that a wealthy person who can afford healthcare can present to a public hospital and have complex and very expensive treatment essentially at no cost.

There are also many other issues which the Commission has not addressed. These would include the importance and efficiency of Consultant-led services, the importance of transport arrangements for patients requiring complex treatment, re-organisation of tertiary and quaternary services to concentrate workforce resources, rationalisation of complex hospital services and procedures, and the list could go on. Creating more bureaucracy for unemployable administrators will not solve the problem. There will have to be involvement in a planning sense by professionals from different sections of the healthcare workforce who are committed to delivering a sustainable workforce and subsequently a healthcare system of which all Australians can be proud. This is not an insignificant challenge, but it is one which must be addressed immediately.

In conclusion, I think the Commission has made a reasonable start on this very complex and important issue. However, I feel that it has failed dismally in terms of the detail, and many of the recommendations are in fact relatively broad, unfocused and relate to creating more bureaucracy. I do not for one moment underestimate the difficulties of the Commission reviewing the subject, but nevertheless, I do not think that the document will do much to address the issues that must be addressed in the 21st Century in Australia.

Yours sincerely

Arthur J C Richardson
Chairman