AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS

Response to the

HEALTH WORKFORCE STUDY POSITION PAPER

of the

PRODUCTIVITY COMMISSION

10 November 2005

EXECUTIVE SUMMARY

The Australian and New Zealand College of Anaesthetists (ANZCA) made a submission to the Health Workforce Study of the Productivity Commission, sent a representative to the Round Table held in Melbourne, and wishes now to make a submission in response to the Position Paper.

This submission comments on the Position Paper generally, and on aspects relevant to anaesthesia in particular:
While supportive of many of the Proposals, ANZCA has a number of concerns relating to Draft Proposals 3.1 and 3.2, 4.1, 5.1, 5.2 and 5.3, 6.1 and 6.2, 7.1, 7.2 and 7.3, 8.1 and 8.2, 9.1 and 9.2, and Appendix B.

The College would like to suggest that the Productivity Commission review the original ANZCA submission, which provides a balanced, well referenced review of anaesthesia services, including non-medical members of the anaesthesia care team.

INTRODUCTION

Anaesthesia is a broad area of medical specialist practice which underpins many services in acute care hospitals, public and private, metropolitan, outer metropolitan, rural and remote.

ANZCA Fellows play a key role in orchestrating peri-operative and peri-procedural services in these hospitals.

Anaesthetists are also involved in the provision of intensive care, medical retrieval, and in acute and chronic pain management, as well as in hyperbaric medicine. Fellows of the Joint Faculty of Intensive Care Medicine (JFICM) and the Faculty of Pain Medicine (FPM) are the specialists responsible for the provision of intensive care and pain medicine respectively.

The roles of ANZCA, JFICM and FPM are to set standards, and to oversee training and graduation, and Continuing Professional Development of the relevant specialists.

DRAFT PROPOSALS 3.1 and 3.2

Recognising the short term need for Overseas Trained Specialists (OTS), and assisting jurisdictions in facilitating the assimilation of OTS into the Australian medical workforce, ANZCA strongly supports the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, as stated in Proposal 3.1, and regular reviews of progress in implementing the NHWSF.

ANZCA is signatory to a contract with the Commonwealth Department of Health and Ageing (CDHA) to form a Rapid Assessment Unit for OTS. ANZCA has also exceeded Australian Medical Workforce Advisory Committee (AMWAC) targets for trainees, and further comment will be made on Appendix B and Box 1 (page XXIII), in both of which, incorrect figures on the anaesthesia workforce are stated.

DRAFT PROPOSAL 4.1

In relation to this proposal, ANZCA was disappointed that no reference was made to its well researched and very balanced submission regarding health workforce innovation, with particular reference to anaesthesia.

Instead, the Commission appears to have relied on information from Professor Wayne Gibbon and Professor Stephen Duckett.

Professor Gibbon has no credibility in relation to proposals put forward for the introduction of nurse anaesthetists to Australia. While ANZCA provided a well referenced, balanced review of international trends in this matter, and provided its pro-active views, Professor Gibbon appears to have relied on material from the American Association of Nurse Anaesthetists' website on Certified Registered Nurse Anaesthetists, some of whom practise independently of medical supervision in only a few states of the USA.

Rather than repeat detailed information from our original submission (which we urge the Commission to re-evaluate), ANZCA would like to re-iterate that it has no objection to, and would promote enhancement of the role of assistants to the anaesthetists, both nurses and technicians, in Australia.

ANZCA is of the view that the model currently being developed in Canada is much more appropriate than other models, whether from the USA, UK, Europe, or developing countries.

Professor Duckett, on the other hand, is credible within his areas of expertise. However, his recent papers "Health Workforce design for the 21st Century" and "Interventions to facilitate health workforce restructure" do not provide a balanced and useful view of anaesthesia providers, as was done in the ANZCA submission. His conclusion in the first paper cited above that "Preparation of the health workforce in Australia requires radical transformation" refers particularly to the USA, and ignores Canada, while the second paper simplistically proposes that task substitution should include replacement of "anaesthetists" by "nurse anaesthetists".

In support of his views, he quotes papers by Simoens, Buchan, and Sibbald as parts of the OECD publications, and Sibbald and de Bie.

On reviewing these sources, Sibbald, in the conclusion to his paper "Changing the skill-mix of the health care workforce" states that "the findings from existing research need to be made more accessible while the dearth of evidence makes new research necessary."

Simoens has published OECD working paper 19, which not only states that nurse shortages exist in all OECD countries, but that these shortages will worsen. It is of interest that the OECD Report "Towards High Performing Health Systems" refers to the Victorian situation regarding nurse labour supply.

Buchan's OECD Working Paper 17 on "Skill-Mix and Policy Change in the Health Workforce: Nurses in Advanced Roles" provides advice to countries considering implementing advanced roles for nurses. This was included in the ANZCA submission.

De Bie, writing on "Reserved procedures in Dutch hospitals: knowledge, experiences and views of physicians and nurses" was reserved, concluding that "the functioning of the reserved procedures regulations in hospitals is considered to be moderately positive."

PROPOSALS 5.1, 5.2 and 5.3

ANZCA has comments in two areas.
Firstly, we have concerns about the Australian Government transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education Services and Training to the Department of Health and Ageing, without knowing more details about this proposal.

Secondly, the Position Paper appears to concentrate on the role of Universities, and does not give adequate recognition to Colleges as training and examining bodies, and providers of continuing professional development.

The Colleges have operated in some cases for over 70 years, at relatively low cost to the community, producing a high quality workforce and setting the standards of the excellent health care system currently enjoyed by Australians.

PROPOSALS 6.1 and 6.2

While accepting the need for greater efficiency in accreditation for university- based and postgraduate health workforce education and training, ANZCA believes that a major advance has been the extension of national accreditation of undergraduate medical training institutions by the AMC to include national postgraduate medical training institutions. Dilution of this excellent process by introduction of another accreditation agency, or abolition of the AMC would be a retrograde step.

A national approach to assessment of overseas trained health professionals is badly needed. The AMC/CPMC process was and is a good model, and is being reviewed by the Department of Health and Ageing, but will only work if State and Territory Health Departments and Medical Boards support the process.

Proposals 7.1, 7.2 and 7.3

Uniform national standards for registration and mutual recognition are badly needed in Australia.

Task delegation is referred to in comments under proposal 4.1 (above).

PROPOSALS 8.1 and 8.2

Introduction of rebates payable where provision of services are delegated by the practitioner would need to be carefully planned and monitored. Will this in fact increase healthcare costs?

PROPOSALS 9.1 and 9.2

Workforce planning is complex. The expertise of AMWAC and the Medical Training Review Panel (MTRP) should not be lost in any restructuring.

APPENDIX B

The statement that there is a small shortfall in the anaesthesia workforce is correct, but it should be recognised that the AMWAC target for numbers of ANZCA trainees, and the annual output from the ANZCA training program now exceed AMWAC targets.

This correction needs to be applied to Box 1 on page XXIII as well.

The correct figures, as supplied this year to the Australian Medical Council (AMC), MTRP and the Australian Consumer and Competition Commission (ACCC) are as follows:

The 1996 AMWAC Report recommended that ANZCA increase year 1-4 training posts from 369 in 1995 to 489 by 2006.

The 2001 AMWAC Report recommended that ANZCA increase year 1-4 training posts to 512 by 2003, with an output of 128 graduates a year.

Up until 2004, when posts were abolished in favour of accreditation of training hospitals, AMWAC reported only on Year 1-4 posts, and did not include the 5th, or Provision Fellowship year positions in their calculations.

Following removal of posts in favour of training hospitals, where the numbers of trainees are limited principally by jurisdictional funding, the total number of financial registered trainees in 2005 is 755, or notionally 151 in each of the 5 years of training. This would be equivalent to 604 in the first 4 years of training, well in excess of the AMWAC target.

ANZCA graduated 123 Australian New Fellows by training and examination in 2001, and in 2005 this has increased to 135, in excess of the AMWAC target. In addition, ANZCA has also awarded Fellowship to 23 OTSs in 2005, and continues to support training of General Practitioners in anaesthesia through the Joint Consultative Committee (JCCA) of the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

IN CONCLUSION, the Position Paper does not address issues such as the Commonwealth-State and Territory division of funding. Nor does it emphasise the need for retention of the health workforce. There are many thousands of health workers in Australia who will no longer work in the health environment, particularly in the public sector. The conditions, the quality of care, and the goodwill of health workers have all been progressively eroded over the last 20 years.

Yes, Australia has a “good” health system, but it is on the brink, especially in the public sector, especially in rural and remote areas.

A recommendation of the Canadian Romanow review was that funding be put back into the public health system to remedy deficiencies.

It is a pity that the Productivity Commission does not appear to share the same view. The massive increases in both medical school graduates from 2010, and the large numbers of OTS and OTDs in Australia require a fully functioning public health care system, in addition to involvement of the private sector, as proposed by the Commonwealth Department of Health and Ageing.

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