Council of Procedural Specialists

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Response to the Productivity Commission Paper September 2005

1. **The Standard of Australian surgery is world class**
   The **standard of Australian surgery and the training of our surgeons is world class**. This has been achieved because of the devotion, skill and dedication of medical practitioners acting as voluntary trainers. Australian surgeons founded the Royal Australasian College of Surgeons (RACS) and its related specialists bodies as a voluntary, professional college to improve and maintain surgical standards and public safety in Australia. The model has worked extremely well. Any erosion in the role and confidence of medical colleges is likely to adversely affect the standard of medical training in Australia. There is no guarantee that once the college training system is dismantled or eroded that medical standards will continue to be world class.

2. **Public hospital financing policy inhibits productivity in our public hospital system**
   It is government policy to offer all Australians the unattainable promise of unlimited high quality health care on demand at no direct cost to the patient, through our public hospital system. We all know in reality this cannot be delivered without each patient being properly funded as they come through the public hospital system. Despite taxpayers spending $18 billion p.a. on public hospital care, our surgeons struggle to get theatre time and resources to meet the expectations that governments have created. Demand is dampened by rationing and misallocation of resources to our public hospital system. Any study of the productivity of the Australian medical workforce is flawed without an appropriate analysis of how the public hospital Medicare funding system adversely impacts workforce productivity. This analysis should test the extent to which Gammon's Law is operating in our public hospital system. Namely that in a bureaucratic system, increases in government expenditure result in declines in productivity through a process labelled 'bureaucratic displacement'.

3. **Workforce planning forecasts are speculative guesswork**
   Predictions of future workforce demand and workforce requirements are at best speculative. This is particularly the case when long training times are envisaged in an environment of changing technology and medical breakthroughs that can make skills redundant overnight. What looks like an area of future shortage can quickly become an oversupply or vice versa. **What is required is sensible, steady, and achievable expansion of the medical workforce maintaining quality and standards** whilst allowing individuals to make their own career decisions in an uncertain environment. In any event any expansion in surgical training requires a massive investment from state governments whose budgets are already under pressure. It is easier to blame the medical colleges than fix this problem. No-one can accurately predict what the demand will be in each specialty particularly when long term forecasts are required. The only thing we know about medical workforce planning in Australia is that it has been consistently wrong as has been estimates of future health care expenditure.

4. **Quality must always be paramount in medical training**
   Whilst colleges have in general been willing to train sufficient surgeons and specialists to meet the needs of the Australian public they should never abandon an insistence on high standards for successful graduates. To do so would be to place the public at unnecessary risk. In recent

times government agencies, state and federal have exerted pressure on colleges to produce increasing number of graduates and relax standards. Such pressure will ultimately result in doctors being unwilling to train those who they believe are not suitable. Only competent, practising, clinical professionals are in a position to judge the skills of those who seek the authority to operate on patients. Their collective judgement must be reinforced not eroded, if public safety and standards are to be maintained. A procedural specialist must perform at a high standard of mental and manual dexterity. Governments must support and reinforce the role of colleges in the maintenance of high standards. Lowering standards adds to costs and public misery. Colleges, in the interest of public safety should never apologise for high standards of surgical training including entry standards. Undoubtedly this system of training doctors will have its critics and occasional anomalies. Australian medical colleges are far more transparent than most commercial and government organisations. A key indicator of a society with poor medical care is the absence of strong, well resourced and independent medical college system.

5. **Medical colleges are community assets**

There has been no conspiracy to limit surgical numbers. Doctors train their own competitors at no direct cost to the taxpayer. This represents billions of dollars of voluntary training by the profession on behalf of the Australian community. If this voluntary training is withdrawn or eroded, the Australian taxpayer will be left with considerable cost of finding and funding alternatives.

6. **Cutbacks and rationing in the public hospital system undermines training**

The public hospital system has been the traditional facility for training young surgeons. As cutbacks occur through inability to make hospital Medicare work, training opportunities are lost. Pressure is then mounted for the profession to dilute and hence de-value training. Any resistance to this pressure is met by accusations of number restriction. Opportunities for training in the private sector will require the co-operation of private specialists and their patients as well as private hospitals. This will not fix the core problem. Namely the increasing competition for theatre time and access to patients in our public hospital system as it is currently funded and managed.

7. **Statistically Australia has enough doctors**

By world standards, Australia has a healthy doctor/patient ratio. Singapore has a world class health care system with half the number of doctors per head of population. What Australia has in common with many countries is a city/rural imbalance. As dis-investment in health infrastructure occurs in our rural areas we will see no significant change to this phenomenon. New graduates and overseas trained doctors want to work where they are well supported and properly resourced. Focussing on numbers alone is masking problems associated with productivity and lifestyle changes. Stepping up the production of doctors will not of itself remedy many of the perceived shortages e.g. the lack of public hospital infrastructure for the mentally ill is a massive dis-incentive for young Australian doctors to practise psychiatry. Hence perceived workforce supply problems are in reality infrastructure, funding and policy problems.

8. **De-medicalisation will increase uncertainty and anxiety over medical standards**

There is no evidence that Australians have lost faith in the way our doctors have been traditionally educated, trained and recognised. Attempts to erode the confidence of established medical institutions and blur the roles of doctors by creating quasi medical professionals who have not undertaken the rigours of medical training will simply add to confusion, concern and uncertainty at a time when Australians are looking for security and confidence in the institutions that have delivered world's best medical care.

Recommendation

That Federal and State Governments immediately desist from interference and agenda setting in the training of Australian medical specialists and allow the profession through its learned colleges to continue to train and develop world class medical practitioners.

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10 November 2005

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