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Australia's Health Workforce

Comments from the Australasian College of Podiatric Surgeons to the Productivity Commission Position Paper. November 2005

Introduction

The Australasian College of Podiatric Surgeons (ACPS) welcomes the Productivity Commissions Position Paper and the opportunity to make further comment. The proposed reforms contained in this paper are generally recognised by the ACPS as an appropriate response to the difficulties that the Australian health sector must confront in coming years.

While encouraged by the draft proposals we remain concerned about the ability to effectively implement broad health care reforms in the Australian context due to several factors, not the least of which may be the dominant and protectionist position held by various elements of the health industry.

The ACPS has worked successfully with the Commonwealth - resulting in legislative reform aimed at improving equity for the consumer of private health insurance. The practical outcome has been far less satisfactory than was hoped. It seems that the health industry lacks an independent, strong regulator to ensure that positive reform can be translated to public benefit. We note the Commission has not addressed this issue. We would like the Commission to examine the ability of the health industry to demonstrate essentially uncontrolled anti competitive behaviour. Why are health markets any different to the telecommunications market?

The chapters relating to Workforce Innovation and Funding Arrangements are of most direct relevance to the ACPS and our response will in the most part be directed to these areas. Draft proposals 4.1 and 8.1 and the associated recommendations in particular highlight the fit of podiatric surgery as an appropriate case example of the philosophy which underpin the position paper.

The ACPS response to the position paper will highlight the potential difficulties in implementation utilising the road to policy reform that podiatric surgeons have endured and

the ongoing difficulties faced by this group. It should be noted that the ACPS has on the advice provided by successive Federal Health Ministers refrained from requesting Medicare rebate for professional services. It has been the understanding of the ACPS that lack of MBS rebate for professional services should not obstruct delivery of services – given the current circumstance facing podiatric surgeons this view would appear to be naive.

Podiatric surgery should be identified by the Productivity Commission as a speciality worthy of immediate assistance to enable enhanced service delivery to the Australian public. This group of practitioners already exists, is endorsed by the Commonwealth, but is struggling against the very issues identified throughout the Commissions position paper. The experience of the ACPS suggests that reform will not eventuate without strong policy leadership. The reform process needs to be tested; podiatric surgery provides the opportunity for such practical investigation. Ongoing theoretical debate has the potential to see a repeat of history where little effective change ever eventuates.

Summary Recommendations

The ACPS would like to take part in further roundtable discussions of the Commission.

While the Commission did not offer any judgement about the merits of particular changes, when discussing workforce innovation it did highlight and use podiatric surgery as a case study to illustrate the lack of formal process to explore the merits and consequences of innovation. Draft proposal 4.1 alludes to the need for resource allocation based on objective outcomes measurement. This philosophy has been espoused previously. In 1997 the Commonwealth funded a report investigating the mechanisms by which outcomes of Acute Health Care should be measured [1]. The ACPS has vigorously pursued such processes in its own research activities. This again demonstrates the "fit" of podiatric surgery as a benchmark for reform.

The ACPS feels that as a case example in facilitating workforce innovation it is appropriate to first remove the barriers that exist to the funding of podiatric surgery as suggested in Draft proposal 8.1

- Broadening of MBS to include podiatric surgery
- Provide referral arrangements for diagnostic and medical specialist services subsidised under the MBS to podiatric surgeons
- Prescribing rights under the PBS for podiatric surgeons

Further to implementing draft proposal 8.1, to allow the reform process to occur

- Steps should be taken to effectively implement the parliamentary intent of recent health legislation reform.(Health Insurance Amendment (Podiatric Surgery and other matters) Act 2004) in particular the ability of the private insurance industry to discriminate between podiatric and orthopaedic surgeons for the purposes of private hospital costs should be removed.
- Discuss mechanisms by which podiatric surgeons may take part in "No Gap" programs with private insurers.
- Encourage direction of funds to establish fully integrated podiatric surgical units in the public hospital system including those serving rural and remote areas (United Kingdom model).
- Provide incentive funding to universities for postgraduate podiatric surgical training.

Finally, the requirement for a market regulator to protect the consumer from anticompetitive activities in the health industry is critical to the success of any reforms that are generated from the activities of the Commission.

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Issues Relating To Reform Of Service Delivery (Foot Surgery)

To support the original submission made to the Productivity Commission by the ACPS we have provided additional background information including examples of some of the systemic constraints and identification of some of the issues that confront the reform process. It is the direct experience of the ACPS in seeking reform that causes us to remain guarded about the ability for heath care reform to take place

1. Workforce Substitution

As is acknowledged in the position paper elements of the reforms proposed are not entirely new. In the United Kingdom similar health care reform processes have been proposed and the role of allied health care practitioners expanded to encompass those traditional provided by the medical profession. In a report discussing the challenges of work force substitution the Department of Health in London stated:

> "The traditional entitlements for physicians – such as the exclusive rights to perform certain procedures are breaking down."
> "Indeed current government initiatives stress the need to work across traditional role boundaries and express a desire to break down barriers to change" [2]

Podiatric surgery has in the UK has become an example of the success of such policy shift. Over 50 dedicated podiatric surgical units now function in the NHS and provide highly accountable surgical services[3-6]. The acceptance of podiatric surgery is high within the British medical community reflected by a preference for referring to podiatric surgeons over orthopaedic surgeons by general medical practitioners.[7]

In Australia the subject of workforce innovation and workforce substitution has also been investigated but has not proceeded due to the political pressures exerted by the powerful medical lobby:

Extract from PhD Thesis: Associate Professor Dr Paul Bennett. 1999. An Investigation into Health Related Outcomes of Surgery Performed by Fellows of the Australasian College of Podiatric Surgeons

In 1994, Professor Peter Baume was commissioned by the then Federal Minister for Health, Dr Carmen Lawrence, to undertake an independent assessment of the state of Australia's surgical work force. Baume has criticised the tight control on training the surgical work force by the Royal Australian College of Surgeons (RACS), which he linked to high-income maintenance. Professor Baume called for new initiatives at a Federal level to deal with this problem. This position received support from the then Commonwealth Department of Health and Family Services secretary Dr. Stephen Duckett, who commented, "We need to be looking at alternative ways of assuring access to the skills of health professionals other than doctors, for those with a clear need for the services of those health professionals". Specifically, Professor Baume recommended that "to develop detailed options of the areas in which job-substitution would be appropriate, how it might be approached and how barriers to job-substitution might be removed"

The president of the AMA at that time, Dr. Brendan Nelson, criticised the report saying that many of the recommendations would lead to a lowering of standards of specialist care and warned of major confrontation between the medical profession and the Federal Government if the report's recommendations to overhaul the system were accepted. The RACS saw that it is very important to establish sub-speciality groups to provide support in combating intrusion from para-medical groups who do not have the necessary long under-graduate and post-graduate training required for the highest surgical expertise.

The emergence of the "podiatric surgeon" has been identified as a concern by the pre-eminent orthopaedic surgeon, Professor Klenerman in 1991. This concern is embodied by his comment that the rapid advancement of surgical knowledge and specialised techniques used by podiatrist, combined with a lack of orthopaedic interest in foot surgery, may have been the driving force behind why patients seek alternative sources of help.

The AMA's stock response of "diminished quality and safety outcomes" to the concept of workforce substitution is one which cannot be substantiated in the case of podiatric surgery which has shown to be safe and effective with a similar or lower return to theatre than orthopaedic surgeons.[8-16]

A parliamentary review of Medicare benefits (Layton report 1986) described podiatry as "effective, cost efficient and socially acceptable". The report identified an inadequately met demand for podiatry services amongst older people and recommended greater public funding. In addition the report described satisfaction with the overall standards of practice of podiatric surgery but expressed reservations in regards to availability of appropriate safeguards to prevent inadequately trained podiatrists from performing invasive procedures. The granting of professional attention status for accreditation of podiatrist (podiatric surgeons) under the Health Insurance Amendment (Podiatric Surgery and other matters) Act 2004 overcomes the concerns raised.

Interestingly, nearly thirty years ago in the United States, the model of training podiatric practitioners as physician substitutes was recommended as being worthy of the medical profession's attention.

2. Competition

Workforce substitution will result in competition between providers. It was identified some time ago in the United States [17] that having two provider groups has public benefits in that competition between orthopaedic and podiatric surgeons may result in a better quality of service, reduction in costs and improved access to care.

As cited by Gilheany [18], since 1996 when podiatric surgeons began to seek increased Commonwealth recognition there has been exponential growth in the numbers of orthopaedic surgeons expressing an interest in foot surgery. At the same time reforms aimed at improving

access to podiatric surgeons has met with significant resistance from the orthopaedic community.[19]
The barriers in access to podiatric surgeons relate largely to inequities in funding from both governments, state and federal as well as the private health insurance industry. Thus the full benefits of competition between podiatric and orthopaedic surgeons have not yet been realised.

Anti competitive behaviour in the Australian health care industry has been investigated. A press release from the ACCC on 6th February 2003 stated:

> "The ACCC engaged Professor Jeff Borland of the University of Melbourne to examine whether the current supply of surgeons is sufficient. He found likely shortages of surgeons in a majority of surgical sub-specialties including the two largest sub-specialties – general surgery and orthopaedic surgery."
> "The need for reform is heightened by emerging evidence of a shortage of surgeons in Australia", ACCC Chairman, Professor Allan Fels, said today.
> "The ACCC is aware that potential alternative high standard models exist – for example, dental specialists are trained either in universities or the dental college. This contrasts with surgeons whose training is controlled by the College (R.A.C.S.) and does not involve universities."

3. Does Legislative Reform Work?

The Commonwealth of Australia has recently amended health legislative in an effort to even the ground between podiatric surgeons and orthopaedic surgeons. The political process for the amendments took over 6 years [18] and to date despite the successful passing of legislation little change in the disparity between funding for the two providers of foot surgery has occurred.

In the explanatory memorandum to the Health Insurance Amendment (Podiatric Surgery and other matters) Bill 2004 national competition policy was cited as a driver of the policy shift. The memorandum states that hospital treatment provided by podiatric surgeons should be treated under applicable benefits arrangements "as they would if a medical practitioner provided a professional service". The Department of Health and Ageing commented that this bill however makes no changes to Medicare and that the department would not extend Medicare benefits to this group. It should be noted that the allied health provisions in Medicare Plus do include podiatry but not podiatric surgery.

When debated in parliament the Bill received bipartisan support

House of Representatives- Extracts of the key point from Hansard 12th May 2004

Ms GILLARD Shadow Minister for Health and Ageing

"As I stated before, currently under the Health Insurance Act 1973, private health funds cannot pay benefits from their hospital tables for foot surgery performed by podiatric surgeons, as benefits can only be paid to medical practitioners, and podiatric surgeons are not medical practitioners, though they are highly trained."

"In weighing up those factors, clearly diversifying who can provide medical services and claim payment for them, whether that be from private health insurers or from Medicare—should only be done if there is no risk to the quality of patient care. In the example in this bill, it seems that patient care will not be compromised in any way."

"In those circumstances the opposition is prepared to support the bill in its entirety and will be doing so today"

Ms WORTH Parliamentary Secretary to the Minister for Health and Ageing
"This is the sort of workaday legislation that does not get much public notice, but each part of this bill, in its own way, will do something to improve the quality of health care available to Australians."

"There has been concern in some quarters that this is lowering professional practice standards by allowing podiatric surgeons, who generally are not trained medical practitioners, to perform minor foot surgical procedures. I can assure colleagues that this is not so. Podiatric surgeons have been around for a long time. They are accredited under state and territory legislation. They are highly experienced in their craft and are subject to rigorous professional and clinical standards. They are accountable for their work."

"It makes private health insurance a product that is so much more comprehensive and attractive to the hundreds of thousands of Australians who need podiatric treatment at least once in their lives. It gives those people more choice in their treatment options. No longer will they have to be treated by a general surgeon simply because one practitioner attracts a private benefit and the other does not."

The governments advice after the legislative amendments was for the Australasian College of Podiatric Surgeons to "market itself" to the various stakeholders. This is a commendable concept and the college is making as much effort as possible. As a small organization without the financial resources and manpower of the large surgical colleges the task however is almost impossible.

Thus far the overwhelmingly response of the private health insurance industry has been negative. The almost "block" response is that unless a procedure attracts a Medicare rebate private insurers will not support the service.

Senate Committee Hearing National Health Amendment (Prostheses) Bill 2004 Hansard Extract - 7th February 2005

The College also indicated that several private health insurance funds had made it clear that, notwithstanding the legislative recognition given last year [Health Insurance Amendment (Podiatric Surgery and other matters) Act 2004], some funds had indicated that they had no intention of extending their cover to podiatric surgeons' services.

The Committee has great sympathy with this view. While not suggesting that funds should be forced to offer podiatric cover, it is important that fund members either have the option of obtaining podiatric surgical services through their private health policy, or have the option of switching to another policy – or another health fund.

The Committee noted that the College's submission did not make a case for extending private health benefits to podiatric surgeons' services themselves. However, their ambiguous situation highlights that increasingly the regulation of private health cover, including the linking of benefit eligibility to professional services also covered by Medicare, is out of kilter with the reality of providing professional health services.

The Committee considers that it is desirable that future reviews of private health cover should consider seriously the future treatment of podiatric surgery services, whether or not they are also covered by the Medicare Benefits Schedule.

Recommendation 3

1.45 The Committee recommends that future reviews of private health insurance cover should consider whether benefits should be paid for the professional services of podiatric surgeons, whether or not those services are also eligible for a Medicare benefit.

During a Senate Estimates Committee hearing the Private Health Insurance Ombudsman was asked about podiatric surgery:

Senate Budget Estimates Committee Community Affairs Legislation
Thursday 2nd June 2005

Mr Powlay - Private Health Insurance Ombudsman—I have had complaints about this issue on an ongoing basis. It has been general practice across the health insurance industry not to cover podiatric surgery to the extent that other surgery is covered. Part of the reason for that is that podiatric surgeons' surgery procedures do not have Medicare Benefits Schedule coverage and many of the funds link the payment of their hospital benefits to whether or not Medicare will pay.
CHAIR—That is right. Can I interrupt you there—the podiatric surgeons are not seeking MBS: game, set and match. But they are really being very severely discriminated against by the funds, who will say to a patient quite clearly, 'You go to an orthopod and you're covered. Go to a podiatric surgeon who is highly qualified and highly specialized and we won't cover you. Go and row your own canoe; we couldn't care less what you do.' I would have thought that that type of attitude by the funds is well and truly against the essence of what this

government is trying to do, and that is to create a level playing field for people who choose to go to a podiatric surgeon as opposed to an orthopaedic surgeon.

The need for an independent regulatory body with the ability to ensure that the full intention of health reform is implemented is clear. Alternatively for reform to be successful, government should consider framing legislation in terms, which provide strong compulsion in areas where commercial competition is stifled as a result of professional or commercial dominance which is not in the best interest of the community.

4. MBS as a restrictive tool.

While education, training and to a lesser extent registration are issues, one of the main blockages that prevent podiatric surgery from participating in the surgical workforce is adequate funding arrangements not only for the professional fees but the costs associated with the surgery. The government has attempted to facilitate the process by which private health funds can pay a rebate for hospital costs as well as other costs associated with podiatric surgery but an impasse has occurred as funding of the services associated with surgery, both in the public and private systems are linked to the MBS. As MBS does not apply to podiatric surgery the private health industry does not want to provide a rebate, particularly considering if an orthopaedic surgeon who provides the identical service, a MBS rebate applies. This is a form of shifting costs on to the private system which they understandably are rejecting. Podiatric surgery is therefore caught in a "rebate limbo".

This seems to be an insurmountable obstacle for the funding of podiatric surgery in the private sector. If the government wishes the private health insurance sector to take up the concept of reform then this issue must be addressed. It would seem that the only way to remove the largest of obstacles to a more flexible, competitive health workforce is to widen the MBS to include other than medical services as has been suggested in Draft Proposal 8.1.

The assertion is that private health industry is discriminating against podiatric surgeons and not taking on board the intent of the Health Insurance Amendment (Podiatric Surgery and other matters) Act 2004. The intent of the legislation have clearly not been met when considering that

- "Hospital treatment provided by podiatric surgeons should be treated under applicable benefits arrangements as they would if a medical practitioner provided a professional service" (Explanatory Memorandum)
- to give "people more choice in their treatment options" (House of Reps Hansard)
- and "create a level playing field for people who choose to go to a podiatric surgeon as opposed to an orthopaedic surgeon"(Senate Estimates Committee)

The assertion can also be made that government is also perusing an equally discriminatory policy by not providing any funding of podiatric surgery or the associated costs either through MBS or any other arrangement. Services which are ancillary and necessary to the safe performance of foot surgery such as anaesthetic and pathology services are also not rebated by either private health funds or Medicare. Medical practitioners provide these services which are eligible under the MBS. It would seem appropriate that the statement "treatment provided by

podiatric surgeons should be treated under applicable benefits arrangements as they would if a medical practitioner provided a professional service" should also apply equally in this situation in respect to government funding.

It is not reasonable for the Commonwealth to simply deflect the responsibility for this payment to the private health industry. Logically why would a private insurer support such concepts of job substitution when the identical service can be provided to the patient by an orthopaedic surgeon and the government pays?

Under the current arrangement for making changes to the MBS via the Medical Services Advisory Committee and the Medicare Benefits Consultative Committee the ACPS has not yet made any submission for inclusion under MBS. As stated in the introduction it has been made clear to the ACPS by successive Federal Health Ministers that such a request would not be considered. A proposal presented to the Federal Department of Health from the Australasian College of Anaesthetist's to allow MBS rebate for anaesthetic services associated with podiatric surgery has also been rejected.

The articulated logic for extension to medicare is that any concession would potentially open the flood gates to other allied health professions. While podiatry is an allied health profession, given that podiatric surgery is a surgical discipline, it is the only surgical discipline that does not attract MBS rebates so this argument lacks depth. The history of the AMA activity in guarding the gate to subsidized health care through Medicare rebates for professional services should also not be underestimated in such discussions.

To include the services of podiatric surgeons would not require complex administrative process. The Commonwealth already accredits podiatric surgeons and the Health Insurance Commission recognises podiatric surgeons for MBS rebates in association with plain radiographs.

The draft proposal 8.1 for a single, broadly-based and independent body to replace the committees that now advise the Australian Government on the coverage of the MBS would hopefully allows a more transparent review process.

The ACPS notes the proposal to allow delegation of clinical services and funding of such arrangements via a supervising medical practitioner who employs the substitute health worker. This proposal did not specifically mention podiatric surgery. As a point of clarification we do not see that these type of funding arrangements would apply to podiatric surgeons and are more applicable to employed health care workers rather than to independent practitioners such as podiatric surgeons.

5. Resistance to Change

There has been further recent debate in the House of Representatives on the issue of podiatric surgery

Hansard Extract - House of Representatives. Health Legislation Amendment (Australian Community Pharmacy Authority) Bill 2005 Second Reading

Mr Neville (Hinkler) "85 per cent of people over 65 require a range of podiatric services, covering prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs."

"The latest report into the Australian podiatry sector, *Podiatry labour force 1999*, shows that Australia's ageing population drove demand for podiatric services. Logically the demand for podiatric surgery will continue to grow as our population continues to age."

"Although I commend the government for the steps taken to lend further support to podiatric surgery under the Health Legislation Amendment (Podiatric Surgery and Other Matters) Bill 2004, I would like to see it taken further. The bill would have the opportunity to address listing podiatric surgery on the Medicare benefits schedule."

"Our health system is in some ways comparable with the US and the UK, where podiatric surgery is well recognised and well supported. In the US, foot surgery is more commonly practised by podiatric surgeons than orthopaedic surgeons and has parity with them. It is recognised under their Medicare system and their Medicaid system, which supports individuals with low and limited incomes. In the UK, podiatric surgery is regularly performed in both public and private hospitals. It is part of the National Health System, and surgical podiatrists have consultant status. In Scotland, the discipline of surgical podiatry is about to be recognised by none other than the Royal College of Surgeons of Edinburgh."

"Why is this the case when podiatric surgery is a highly successful and cost-effective treatment? It makes no sense. It is not as if these and allied skills are widely available, nor is there a plethora of orthopaedic surgeons, and certainly not in regional areas"

"While I do not subscribe to conspiracy theories, one is inexorably drawn to the conclusion that there is some deliberate obstruction or subtle pressure to see that the profession is held in a rebate limbo."

A major reason that the ACPS is concerned about the reform process proceeding is due to "patch protection" from sections of the medical profession. There has been quite vocal opposition to some of the legislative changes concerning podiatric surgery in Australia from the AMA and in particular the Australian Orthopaedic Association.

A recent paper [20] highlighted the opinions of orthopaedic surgeons on podiatric surgeons.

> "Resistance to podiatric surgery was more evident amongst the orthopaedic foot and ankle specialists".
> "grudging acceptance of the need for orthopaedics to 'catch up to the level' of podiatric surgeons in terms of foot surgical care"

> "Whilst prepared to accept podiatric surgeons as technically competent, most respondents were unwilling to afford them equal status with orthopaedic surgeons and essentially viewed them as skilled empirics"
> "belief that podiatric surgeons took no part in audit practices to assertions that they were resistant to all forms of clinical governance or accountability"
> "Reluctance among several respondents to use surgical 'mistakes' as a lever for criticism, based on an acknowledgement that complications arise in orthopaedic practice with comparable frequency"
> "the fact that podiatric surgeons were not medically qualified appeared to be an insurmountable obstacle"

While this study was conducted in the United Kingdom similar sentiments are expressed in Australia.

Borthwick in his paper also commented that on some of the reforms in the British health care system "Government policy initiatives aimed at multi professional working and co equal partnerships appear to lack any clear underpinning which would suggest a viable alternative to existing hierarchies" Given the parallels with he Australian Health care system we feel the Commission should be aware that resistance to change will occur.

This is starkly demonstrated in NSW where podiatric surgeons have been prevented from working in accredited private hospitals and day centres since July of 2005. An anomaly in NSW law has been brought to the attention of the NSW department of health by the orthopaedic community. The anomaly could be amended with addition of the term "podiatric surgeon" to the list of practitioners which currently only includes medical practitioners and dentists to be able to work in accredited hospitals and day procedure centres in NSW. Given the Commonwealth reforms regarding private hospital rebates for podiatric surgery and the fact that this anomoly only exists in NSW it would seem that such an amendment should be able to be made without resistance. It appears that the delay in the amendment has occurred as a result of direct intervention by the orthopaedic lobby.

6. Occupational Burnout

As the Australasian College of Podiatric Surgeons is a small group without the size, influence and political connections of the established surgical colleges we are concerned about the lack of progress of any health care reforms.

The constant opposition from sections of the medical profession, poor rebates from insurers, constant need to justify our position with members of the public, the numbers of patients cancelling surgery and seeking treatment through orthopaedic surgeons due to poor or no rebates only to find a high gap with some orthopaedic surgeons, the enormous workload required to make numerous submissions and representations to governments, health funds and other stakeholders is leading to a high level of despair amongst fellows of the Australasian College of Podiatric Surgeons.

The work of Mandy and Tinley [21] has shown that Australian Podiatrist's exhibit high levels of emotional exhaustion, depersonalisation and lack of personal accomplishment. This study has shown that stress was commonly related to lack of professional status and recognition. This included lack of respect from other professions, patients and the Australian Government.

7. Training

While governments are actively recruiting surgeons from overseas to meet the shortages of surgeons they are ignoring a locally trained surgical work force that are willing and able to participate in both the rural areas and the public system if the government would provide the appropriate recognition and funding.

There are currently 20 fellows of the Australasian College of Podiatric Surgeons all of whom are currently under utilized and approximately an additional 20 podiatric surgical trainees who are all within 3 years of completion of their studies.
Podiatric surgeons self fund throughout their training – currently no funded positions exist for podiatric surgeons. This in combination with uncertainty about the viability of a career as a podiatric surgeon effectively acts as another substantive barrier.

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