The Royal
Australian and
New Zealand
College of
Radiologists

Submission in response to the Productivity Commission's Position Paper: 'Australia's Health Workforce' from The Royal Australian and New Zealand College of Radiologists

Level 9, 51 Druitt Street
Sydney NSW 2000, Australia

Telephone 61 2 9268 9777
Facsimile 61 2 9268 9799

Email ranzcr@ranzcr.edu.au

ABN 37 000 029 863

Table of Contents

Executive Summary ……..3

Introduction..... 5

Workforce Innovation and Funding..... 5
Proposed reforms to Governance Arrangements in Workforce Planning 5
Job Redesign, Task Substitution and Delegation.....7
In the interests of safety and quality RANZCR supports role extension only in the confines of delegation and adequate supervision by a radiologist. 10
Performing and Reporting Imaging.....10
Initiating a Request for Imaging.....11
MBS Access issues 12

Education and Training..... 14
Clinical Training and Accreditation.....14
Access to training positions 16
Access to training positions - non-medical health professionals.....17
Clinical training in a Service Delivery environment 18
Contributions of individual members to training 19
Assessment of costs involved in clinical training 19
Structure of Training and Regulatory Environments.....19
Assessment of Overseas Trained Doctors.....20

Executive Summary

The RANZCR's view is that the Productivity Commission has not addressed one of the most critical issues in regard to health education and workforce, which is to address the structural disconnects in the health system. There is a need to bridge policy decisions about adequate service delivery, and about appropriate numbers and type of health professionals, and to follow up with sufficient training opportunities for these individuals in the public and private sector.

Whilst the Position Paper includes some very direct recommendations for jurisdictions to contribute to some national workforce reforms (e.g. draft proposals 7.2 and 7.3), it is less clear as to what mechanisms will assist jurisdictions and other stakeholders to effect more sustainable and wide reaching changes involved in the development of a health workforce which is able to meet the challenges in "an environment of demographic change, technological advances and rising health costs."[1]

It is the experience of the RANZCR that whilst high level determinations may be made, there is often a disconnect at the level of implementation, and that this level is the most challenging for all parties involved. For example, the governance arrangements outlined in the draft do not explain how a more centralised structure will address the inherent problems associated with funding for training places or decisions relating to job redesign which may be occurring at various stages in each jurisdiction.

There appears to be no position for instance on the notion of pooled funding, whereby funding for all aspects of training would follow individual health workers. It remains the RANZCR's contention that such a model would address some of the current capacity issues by enabling a wider range of locations and environments to participate in training.

The RANZCR is also concerned that the Commission's comments on job re-design, task substitution and delegation, are being contextually driven by issues of cost and geographic isolation/workforce mal-distribution. While these causal reasons for change are important to consider, recommendations for change should be embedded within areas of clinical expertise, with a dominant focus on the provision of a safe, clinically appropriate service to patients. This is especially the case in environments of technological advances and rising health costs.

In regard to medical imaging, whilst role evolution for non-medical practitioners is now being considered in consultation with relevant professional bodies, with a focus on quality and safety at a national level, there are significant measures to fast

[1] PC report p. iv

track role evolution in some jurisdictions, particularly Queensland, in a manner which does not appear to have a consistent focus on safety and quality. RANZCR is currently considering role evolution with an emphasis on high standards of care that are maintained through the Quality Use of Diagnostic Imaging program. It is imperative that structures are in place for work such as this to be considered in an integrated way in workforce planning.

Introduction

The RANZCR appreciates the opportunity to make further comments to the study on health workforce being undertaken by the Productivity Commission.

This submission primarily addresses the following draft proposals:

- 3.1 Areas of Workforce Reform
- 4.1 Advisory Health Workforce Improvement Agency
- 5.2 Advisory Health Workforce Education and Training Council
- 5.3 Clinical Training Policy Reform
- 6.1 National Accreditation Agency for health Workforce Education and Training
- 8.1 Standing Review Body on the coverage of the MBS

Comments relating to workforce innovation and funding, including job re-design task substitution and delegation, are also included.

Unless otherwise indicated, the comments in this submission refer to the College's sphere of knowledge, namely Radiology and Radiation Oncology.

Workforce Innovation and Funding

Proposed reforms to Governance Arrangements in Workforce Planning

There is clearly a need to better integrate health workforce planning and RANZCR gives in principle support to the some of the proposed reforms made by the Productivity Commission.

Effective health workforce planning must take into account broad factors affecting demand, supply and productivity in health care as well as service planning and these have been outside the realm and scope of AMWAC. AMWAC however has been virtually the sole independent arbiter on workforce requirements and specifically number of trainees required, including by jurisdictions.

Responding to broad workforce pressures

Specialist medical colleges, such as the RANZCR, sought to respond to AMWAC workforce projections, by seeking to negotiate with jurisdictions to provide funding for additional training positions. It has become clear that there has been an increasing disconnect between the analysis and recommendations provided by AMWAC and the rapid developments in health care and in the workforce.

For example, the rapid advance in technology and digital imaging in radiology has led to a significant increase in workload. These changes mean that although the increases in trainee numbers in radiology projected by AMWAC in 2001 have largely been met, the RANZCR workforce survey reports significant increase in the radiology workload, which is unlikely to be sustainable should the projected decrease in workforce occur. International evidence confirms the impact of the digital revolution in diagnostic imaging which is contributing to an exponential increase in images being viewed by radiologists. In 1996 radiologists were viewing 1,500 CT images per day, whereas in 2002, the rate was 16,000 per day[2]. Whilst this has been partially offset by technology advances (data sets) to deal with the results of advances in CT, evidence suggests that rather than reduce hours of work, the technology has led to an increase in hours.

Mirroring many broader changing work patterns in the medical and health workforce, the Radiology workforce is exhibiting a loss of FTEs through increased numbers of new radiologists working part time. The effective expected loss of almost one quarter of the workforce over the next five years through retirement, and a desire of new entrants to work fewer hours will mean that the existing AMWAC projections are unlikely to keep pace with workforce pressures. It is unclear how these issues would be addressed within the framework described in the Commission's recommendations.

It is also increasingly important to consider groups which interrelate in a particular clinical domain, both in respect of service provision and in mapping where shortages in one group have a flow on effect on another. Workforce projections for the range of professionals involved in the provision of medical imaging services, including radiographers, medical technologists, specialist nursing staff and sonographers, need to be considered rather than numerical projections for just one component. Similarly, in relation to Radiation Oncology this means looking at its component groups of Radiation Oncologists, Radiation Therapists and Radiation Oncology Medical Physicists as well as other health professionals involved in the provision of cancer care.

Promoting active partnerships

RANZCR is supportive of the more detailed scenario analysis considered by the Productivity Commission. However, a single body in workforce planning will only improve on the existing structure if it can capture workforce scenarios which reflect the whole discipline. It is recognized that this is especially challenging, but highly important in areas such as medical imaging, which is integral to the diagnosis, treatment and monitoring of a significant number of disease and injuries. It is also

[2] Siegel Eliot. *Image Information Overload: The Challenge* [power point presentation] 2005 [cited 2005; impact of digital revolution in diagnostic imaging more than in any other specialty].

important that the basis for projections is not historical need, rather that tools are developed to enable assessment of need within an evidence-based paradigm.

To accurately capture the complex scenarios requires a governance arrangement through partnerships where all the key players are actively involved. This needs a systemic approach where undergraduate training, advanced training, clinical supervision and shortages in specific areas and related disciplines are considered in unison by all stakeholders. The common link to scenario planning should not be at the highest level of governance but at the level where clinical relevance can contribute to the most effective responses.

In addition, where professional groups are shouldering productivity increases as a result of demand increases and where these have resulted from government policy changes, such as are emerging in Radiology following the introduction of the Medicare Safety Net and other initiatives, these factors need to be considered in workforce projections. Other factors such as the increasing difficulty meeting attrition, needs to be part of a measured analysis.

Presumably the attention given to the proposed Advisory Health Workforce Agency and the principles of the National Health Workforce Strategic Framework will enable determinations regarding these issues to be made. However, it is not clear what the broader governance relationships will be and what mechanisms will be set up to enable input from key stakeholders, including professional groups and jurisdictions, to collaborate on workforce projections and to provide more detailed input.

The recent ACCC /AHWOC joint Review of Australian Specialist Medical Colleges recommended that Colleges and jurisdictions develop mechanisms for consultation about workforce size and distribution, whereby jurisdictions make decisions about optimum workforce numbers and colleges advise about capacity to train. The draft proposals regarding health workforce innovation and the health education and training interface made by the Productivity Commission are not inconsistent with the ACCC/AHWOC recommendations. It would be beneficial nonetheless for the Commission to comment on what mechanisms might support and enable better coordination of the proposed two levels of workforce planning, both through the proposed single secretariat and between professional groups and jurisdictions.

If structures and funding arrangements are not put in place to link workforce planning between what are essentially the two tiers of government, then the existing barriers in implementing increases in workforce and training numbers are likely to continue.

Job Redesign, Task Substitution and Delegation

In the case of radiology, quality and safety, especially in respect of the dangers associated with the use of radiation, are real issues and cannot be ignored. These

are relevant to both the performance of imaging and to initiating a request of an image. There is clear policy recognition of this issue, by way of specific continuing medical education requirements for rural and remote GPs who intend to provide plain x-ray imaging and reporting services.

In considering issues of job redesign, specifically where task substitution and delegation are options, adequate supervision and skill level are of paramount importance in specialty areas like radiology. At the specialist levels of medical practice, it should not be assumed that sets of competencies can necessarily span across both medical and non-medical groups. The approach described in the Commission's report (p:124) proposed by Professor Stephen Duckett supporting greater delegation of tasks described as 'less complex', portrays a view that tasks in medicine are mechanistic and fails to recognise the level of complexity and value add in the medical specialist field.

To understand the complexity of the role of the radiologist, for example, requires an examination and understanding of the complex skill and breadth of experience that defines the specialist domain. Defining where task substitution can occur where quality and standards are not likely to be compromised must occur in close consultation with the clinical field.

RANZCR would question the use of Professor Wayne Gibbon's submission to demonstrate the need for reform on the basis of unmet service delivery[3], because in Australia and New Zealand it is rare that plain films go unreported even in Emergency Departments. Research by the College has failed to find any empirical data on the rates of unreported films in Australian radiological practice, either public or private. There are anecdotal reports that indicate some unreported films in Tasmania and some parts of Queensland. Where this is the case, policies are being considered to train registrars to report on films. It should also be noted that improvements in medical technology mean that the Picture Archiving Computer System (PACS) will streamline the process of reading and reporting images.

To take the example used in the report further, the reporting of plain x-rays is considered by radiologists to be difficult and fraught with error and in many cases even registrars report plain film only under supervision. Plain film may have the most subtle of findings (compared to CT or MRI) and success at this perceptual task is based to a degree on experience. This is the area most exam candidates have difficulty with. In reality one could consider the two main image interpretation requirements as perception (above) and analysis (which requires a strong clinical knowledge base).

The Radiologist is a consultant in diagnosis and treatment, in patient care and in multidisciplinary teams. Radiologists possess a set body of knowledge and

[3] P. 124

procedural skills, which are used to supervise and interpret radiological examinations as well as to perform diagnostic and therapeutic procedures and to make appropriate clinical decisions.

Radiology is essentially an integration of anatomy, pathology, clinical knowledge and other diverse skills, and experience. Unless practitioners meet all of the competency requirements including clinical knowledge and understanding of relevant pathology then reporting of x-ray should not be opened up to other groups.

The international evidence cited by Professor Gibbon and referred to in the Commission's position paper, which is used to support his call for radiographers to be trained to read plain film, requires further careful analysis. The meta-analysis [4] is largely confined to x-rays of the skeleton with only 5% of the chest and abdomen. On that basis there may be evidence that appropriately trained (2-4+ yrs in some papers) radiographers can report skeletal X-rays, although comparison was often with trainees rather than radiologists. There seems to be no evidence for the blanket statement regarding all X-rays in the conclusion of Professor Gibbon's paper.

RANZCR notes however that the UK model for role extension of radiographers came about as a result of severe workforce shortage where up to 20% of films went unreported, but that such critical shortages are not evident in Australia or in the US. Increasing the scope of practice of radiographers may not be of benefit to overall workforce capacity given that radiographers are themselves in short supply.

It is worth noting that recent evaluations and cost benefit analysis of radiographers interpreting images in the UK suggests that with additional training required it is no more cost effective for radiographers to report than radiologists[5]

In Australia we need to think carefully about the clinical sphere before making these widespread changes, including consideration of medico legal issues. Employers and their indemnifiers need to carefully weigh up the advantages of substituting practitioners to provide services where there are options for the highest quality specialist services available.

The scientific rigour that assessment of new technologies and applications (to be introduced in Australia) are subjected to, via Medical Services Advisory Committee (MSAC), should be equally applied to policy decisions about interpretation and reporting of diagnostic radiology modalities.

---

[4] Brealey S et al, *The costs and effects of introducing selectively trained radiographers to an A&E reporting service: a retrospective before and after study.* The British Journal of Radiology, 2005. Vol 78 p. 449-505.

[5] ibid

A large number of other specialties use radiologists as clinical consultants and advisors in complex cases, rather than just as technical advisors. In general, medical practitioners and medical specialists rely on the experience and intellectual skill of the radiologist in meeting the medical and clinical objectives in each case. Peer to peer communication is the basis of radiology reporting and this cannot be delegated to others. In large radiology practices and public hospital radiology departments, there is an increasing tendency for subspecialty radiology practice where the radiologists, generally with 2-3 areas of interest, work with the corresponding clinical teams as integral members of these teams. This is the best model for optimising utilisation of imaging services with the best outcome for patients. This complexity cannot be met by the proposed role extension.

In the interests of safety and quality RANZCR supports role extension only in the confines of delegation and adequate supervision by a radiologist.

The RANZCR position is that task delegation can only be considered when:

- there is a clear national shortage in the specialty area
- there is no shortage in group extended to take over the task
- supervision from specialist radiologist is possible.

Performing and Reporting Imaging

The Quality Use of Diagnostic Imaging (QUDI) Program, being managed by the RANZCR under contract from the Australian Government Department of Health and Ageing, is exploring these options through the project: 'QS3 – Role Evolution' Project' which will identify and recommend pathways for extending the clinical role of non-medical imaging practitioners and extending the capacity of the radiologist to focus on patient care.

It is noted however that although this exploration is an important one, and has much to recommend it, in the short term it must be explicitly recognized that there are shortages of these health professionals, and that an evolution of their roles through job redesign may subsequently require task substitution of activities which

are currently within the scope of practice of radiographers, sonographers and nuclear medicine technologists. Amending the scope of practice for radiographers, for instance, in the longer term may have an important role to play in retention of these health professionals in the Australian workforce.

National Standards for professional registration and mutual recognition across jurisdictions, as well as local credentialing, will assist with some of the issues raised about quality and safety in relation to job redesign in radiology and radiation oncology. It is noted that in the case of radiographers, sonographers and radiation therapists there are not nationally consistent regulatory arrangements, indeed these important professional groups are not even required to be registered in some jurisdictions.

Whilst workforce shortages and geography may be contributors to a move towards job re-design, task substitution and task delegation should recognize that some health professionals are better suited to specific tasks than others because of the existing nature of their training. It is a concern that some health workers are being considered in job redesign on the basis of geographical location and in areas of extreme workforce shortages which may be the case for Aboriginal Health Workers potentially performing x-rays[6]. The additional set of skills for instance needs to include standards and quality measures for decisions to initiate tests, to conduct tests and to ensure adequate follow up by suitably qualified medical practitioners.

In these instances tele-radiology has a role to play, as it seeks to meet the twin challenges of access and quality. The QUDI program project QS7 will establish technical and practice standards for accreditation requirements for clinical tele-radiology.

Initiating a Request for Imaging

Nurse Practitioners and Nurse Consultants are increasingly aiming to take on roles in initiating medical imaging. In considering a patient management pathway, it is unclear how reporting and treatment might be managed between a nurse practitioner and other health professionals. In radiology this may mean that the reports from radiologists will be returned to the nurse who initiates the request and in some cases where medical practitioners have not delegated this task the nurse may be expected to make decisions based on reports from radiologists, without the same level of clinical knowledge as a medical recipient of a report. There may therefore be a need to consider changes in the way that reports are written and presented, if in future they are being received by a wider range of health professionals.

[6] PC Report p. LX

Clinical Nurse Specialists and Nurse Practitioners who are highly skilled in some domains in radiology may be well placed to initiate requests for imaging, however issues of capacity especially in areas of widespread health workforce shortage where there are no radiographers and/or sonographers to conduct the tests, and no radiologist to interpret results need to be considered. Especially in instances where the report is provided remotely, the availability of communication and advice to the referring practitioner is critically important.

In a similar vein to the structure of credentialling developed by the Australian Council for Safety and Quality in Healthcare [7]the environment in which the practitioner is operating is as vital a consideration in determining whether they should be credentialed to undertaken certain tasks and procedures as their individual expertise or experience.

The Nursing and Nurse Education Taskforce (N [3] ET) has been formed to report to AHMC and AHMAC on scoping and to develop standards for Nurse Practitioners. RANZCR has provided input to the Taskforce on the role of nurses in radiology and radiation oncology. This arrangement enables input from key stakeholders and similar coordinating structures need to be put in place for considering job redesign across many of the areas where generalist health workers are likely to take on roles which have up to now been in the medical specialist domain.

RANZCR agrees that a framework for delegated services needs to be established (Draft Proposal 8.2) to ensure safety and quality and the training and qualifications that will be required. However, because of the advances in imaging technology, the cognitive input of the radiologist is becoming more important, as is their clinical role in providing advice on the most appropriate test for investigating different clinical problems. The decision making processes cannot therefore be delegated, only the tasks associated with carrying out the functions of imaging.

MBS Access issues

In principle, the College supports the establishment of an independent standing review body with a broader role in determining coverage of the MBS (Draft Proposal 8.1).

Two things will assist with reforms to the MBS. Firstly there needs to be close linkages between MBS review and work carried out in other recommended strategic reform areas such as in Draft Proposals 3.1 and 4.1 where demand and supply scenarios can make explicit the areas of shortage and the most appropriate task

[7] ACSQHC, Standard for credentialling and defining scope of practice – A national standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals, July 2004

delegation options occur through coordinated workforce planning (Draft Proposals 9.1 & 9.2).

Currently radiology services include diagnostic radiology, ultrasound, computed tomography, magnetic resonance imaging and nuclear medicine imaging and interventional imaging. MRI requires referral from a suitably qualified medical specialist. Diagnostic imaging services (as described in the MBS) consist of two distinct parts: the procedure, which is the capturing of the images (for example, the x-ray film); and reading of, and reporting on, those images by a medical practitioner. With advances in technology, these two components need not necessarily be done at the same time or at the same location. There are exceptions which require personal attendance by a Radiologist in regard to some procedures.

The critical issue in relation to greater access to the MBS in respect of initiating request for medical imaging by other than medical health professionals is to ensure the clinical appropriateness of those referrals for imaging services. Currently the responsibility for the clinical relevance and necessity for an imaging service rests predominately with the referring medical practitioner. There is limited provision for a radiologist to substitute a more appropriate test. A limited number of tests are able to be ordered by allied health practitioners – those limitations are based on the connection of the investigation to the other health intervention being provided.

With rapid and significant advances in technology there is a case for the radiologist to have a more consultative role and a more integral place in the clinical team. This consultative role may hold greater significance if changes were made to allow imaging requests to be made by non-medical practitioners. In particular, issues about appropriateness, risk and safety could be canvassed by consultation with the Radiologist. This would help to address potential issues of inappropriate imaging. Task substitution needs to consider a reduction in workload at the specialist end.

Particularly within the present framework of a capped budget, risks of over servicing would also need to be managed. Delegation or role evolution involving radiographers reading and reporting on plain x-ray films however is unlikely to drive up demand, which occurs at the point of referral, rather than service provision.

It is also noted that at present, there are specific referral requirements for certain imaging tests, when eligible for re-imbursement under the MBS. This includes a requirement that only medical specialists are able to refer for an MRI or PET scan. These specific examples would need to be noted and duly considered in any review of access of non-medical practitioners to the MBS, in addition to the general restriction on imaging requests by medical practitioners (with a proscribed list accessible presently to Dental Practitioners, Physiotherapists, Chiropractors, Osteopaths and Podiatrists for specified services). These issues would need to be explicitly considered in respect of the effect on demand for services.

The Productivity Commission indicated (p137) that, while outside its remit, some of the proposed changes would require more fundamental changes to the MBS – in regard to interventional radiology and the DIST, RANZCR believes there should be a total review of the structure of the MBS with a view to aligning procedures with body systems rather than with modalities – with the object to facilitate more effective selection of appropriate procedures, to reduce inappropriate imaging and would enable better alignment with contemporary clinical practice.

A qualification in support of Draft Proposal 8.1 would be that the new body would need to address the criticisms of MSAC as it affects the assessment of new imaging technologies. The RANZCR Quality Use of Diagnostic Imaging (QUDI) Program is about to commission a study aimed at identifying assessment and appropriate take up of new imaging procedures and technologies. It is envisaged that this project would include comprehensive literature review, a review of the system currently employed in the Australian context including performance of MSAC, include a review of models used in other countries and consider funding mechanisms for the various possible evaluation models.

The College considers that MSAC could be more effective. It would continue to be critically important that in reviewing new procedures and technologies, and the manner of their approval for introduction of the MBS, that MSAC review matters not only of cost and clinical appropriateness, but also the base and additional competencies required, and thus issues to be considered when credentialling individuals to undertake the new procedure

Education and Training

Clinical Training and Accreditation

The RANZCR appreciates the intent of the establishment of an advisory health workforce education and training council (Draft Proposal 5.2) and the establishment of a national accreditation agency for university-based and postgraduate health workforce education and training (Draft Proposal 6.1) in achieving better co-ordination of the education and training of all health professionals in Australia.

With regard to Draft Proposal 6.1., the College is keen for there to be explicit recognition of the current processes, and the significant activity which is already underway to enhance accreditation processes for specialist medical education and training through the ACCC/AHWOC review as well as the Medical Specialist Training Taskforce.

As indicated in the Position Paper[8], accreditation of the specialist medical colleges is currently undertaken by the Australian Medical Council (AMC). The majority of colleges have now been accredited through this process.

Historically, each college's training program had evolved separately. Our college has found the process of being accredited and annually reviewed by the AMC a generally helpful one which has enabled each college to be independently reviewed and advised of areas of deficiency or of improvement. The first round of accreditation will be completed in the next 2-3 years. Valuable by-products such as joint workshops between the Colleges and the AMC on matters such as methods of assessment and have a clear capacity for improving consistency,

In recognizing the intention of Draft Proposal 6.1 in regard to facilitating better co-ordination of health workforce education and training, the RANZCR considers it to be of critical importance that issues of structure/process and content are separated out.

The College determines curriculum both in the postgraduate training program environment as well as continuing professional development. The role of professional bodies in this regard is critical for the integration of both existing and evolving areas of knowledge and application to practice and service delivery.

The College recognizes its responsibility to determine a curriculum which reflects the wide scope of medical practice which is flexible and capable of change. The adoption of the CanMEDS principles by the AMC and the specialist medical colleges, provides a solid platform for more explicit detail about what is expected of specialist medical practitioners outside of their area of medical expertise.

As indicated, there is significant reform activity already underway in the sphere of medical specialist training. The RANZCR would be concerned if these current efforts were not incorporated into any future reform activities. Stakeholders such as the College as well as the community will be further frustrated if previous efforts to address these matters are dismissed in their entirety.

The ACCC/AHWOC review is a demonstration of training and workforce review being undertaken at a national level. It also provides a significant indication of the challenges in implementing national solutions within a jurisdictional framework across in that instance multiple medical specialties. The report to the health Ministers included the comment that "the authorization conditions imposed on RACS have had significant resource implications for jurisdictions, both in relation to direct costs and time."[9] It is imperative that there is an explicit recognition that

[8] PC report, p.91

[9] ACCC/AHWOC - Report to the Australian Health Ministers – Review of Australian Specialist Medical Colleges, July 2006, p. 3

agreed national determinations are resource intensive and will require support and commitment at both a political and departmental level.

Access to training positions

As indicated in our initial submission – the major limiting factor in the availability of training positions in Radiology and Radiation Oncology is the willingness/ability of State and Territory Health Departments to fund training positions. The current approach for most jurisdictions of leaving the determination of specialist registrar positions to individual hospitals and area health services, within the context of local budgets is very problematic and does not provide scope for including the private sector. The system has no clear process of ensuring that there is sufficient workforce produced nationally and to take account of jurisdictions which do not undertake training.

The RANZCR believes that it has a role as a key informant and advisor in regard to the determination of number of training positions required. This is informed by work which the College conducts on the current workforce, future demands and of appropriate individual workload.

The College has a direct role in advising on what supervision and infrastructure requirements are needed for training positions. Whether under existing arrangements or within a pooled funding environment for training positions, the College would determine curriculum, continue to have a significant role in the provision of advice about future workforce needs, undertake assessments and ensuring transparent processes for site accreditation.

The RANZCR appreciates however that the decision relating to the establishment of positions is one for employers (public or private). These decisions however need to be undertaken in a coordinated manner which recognizes determinations by an appropriate body. On this basis under current arrangements, the RANZCR has sought to encourage jurisdictions to meet the requirements of training positions determined by AMWAC.

The Commission's report appears to have explicitly recognized that there are efficiency opportunities to be considered in collective planning, such as outlined in Draft Proposal 5.1. This recommends that a single body be given responsibility for allocating the quantum of funding across the mix of places in individual courses and across universities, with a requirement for formal consultation with key stakeholders.

A similar process could be considered for clinical training of health professionals.

A single body (which may be a national one such as the Australian Health Ministers' Conference) would need to determine the quantum of funds available for clinical

training. This is sometimes referred to as "pooled funding". These funds would likely need to be drawn from existing Commonwealth and State/territory health budgets.

A body such as the Advisory Health Workforce Improvement Agency would then need to make determinations about the mix of clinical training positions, and their locations. Funding could then be 'tagged' to an individual health worker in training. It is expected that such a process would increase the development of training networks incorporating teaching and other public hospitals, private hospitals and other private clinic, and community health centres.

Similar to the proposal, outlined in 5.1, it would be of critical importance that formal consultations with key stakeholders groups was developed and included in governance structures.

Access to training positions - non-medical health professionals

Within Radiation Oncology, there are two other key groups to regard in the delivery of radiation treatment, Radiation Therapists and Radiation Oncology Medical Physicists.

In 2004 and again in 2005 for the following calendar years, there has been a prime example of the disconnection between the university and health sector with regard to the completion of training. As a result of the acceptance of the considerable shortage of Radiation Therapists, illuminated by a series of reports[10] the Australian Government through the Department of Health and Ageing, funded a number of additional university places throughout the country.

In order to complete their training, a professional development year must be undertaken in the clinical setting. There have been significant challenges both last year and again this year in funding sufficient places for this to be undertaken. This relates both to the direct financial costs involved (i.e. salaries), as well as the capacity of centres to support a number of new entrants who are not yet clinically competent. It is of some concern however that even with a lead time of 3 years (which is the length of the degree) jurisdictions have not been able to ensure sufficient places. Often this has only come with direct approaches to Directors General and Ministers from the profession. It is noted that Radiation Therapists are still considered a profession of workforce shortage.[11] This demonstrates a key example of what ought, with appropriate governance structures, be avoided with the establishment of a national body which traverses the education and health interface as well as those of state and territory borders.

[10] National Strategic Plan, Baume Inquiry, ROJIG
[11] PC report p. 236

The situation of Radiation Oncology Medical Physicists is highly complex. These individuals are critical to the capacity to provide safe and effective treatment. However, as the initial degree undertaken is not one which would solely relate to future participation in the health workforce they are unlikely to be captured in Draft Proposal 5.1. It is suggested that groups such as Medical Physicists, and other non-direct members of the health workforce such as data managers and clinical informatics professionals be considered within the scope of Draft Proposal 4.1.

It is critical though that processes to consider groups such as these would be incorporated into the work of the proposed Advisory Health Workforce and Education and Training Council, as well as the proposed National Accreditation Agency, as there is a specific clinical training program in place, and their professional body, the Australasian College of Physical Scientists and Engineers in Medicine is also that which provides advice in respect of overseas trained medical physicists.

Clinical training in a Service Delivery environment

The RANZCR believes that it is critical for the majority of clinical training for Radiologists and Radiation Oncologists to be undertaken within a clinical setting, which we understand is recognized by Draft Proposal 5.3. Integral to this is the recognition that those individuals undertaking structured training through a specialist medical college are also a key part of service delivery within any department, hospital, private practice or other health facility. Obviously the level of contribution able to be made, depends on the level of experience and expertise of each individual, and the provision of appropriate support and supervision.

At present, a definitive determination of the capacity for independent practice is made as the result of both a completion of time required, and an assessment through a bi-national examination. The RANZCR considers that it has a responsibility to ensure however that in accepting that the service delivery imperative is real, that trainees should not be put into situations in which they undertake tasks which they are not competent to perform.

Some aspects of the accreditation of sites or facilities for training may be able to be streamlined as discussed in the AHMAC submission[12], and as anticipated through Draft Proposal 6.1. There will however continue to be issues related to standards of practice which are only able to be effectively addressed within the scope of a professional body, whose responsibility is to set and assess standards of practice.

[12] PC report, ref. p, 95-96

Contributions of individual members to training

RANZCR members recognize that they have an ongoing responsibility to support the training of the next generation of Radiologists and Radiation Oncologists. It should also be noted that the income received from RANZCR trainees does not support its educational activities. These costs continue to be subsidized by the fees raised from the membership as a whole. This is also the case in respect of the significant commitment of time by specialists, both in work hours (often taken as unpaid leave) and outside of work hours undertaking tasks such as preparing and marking examination papers, preparing and running examination courses and conducting examinations.

As workforce shortages continue to increase, it is becoming more difficult for many individual examiners for instance, to be released from duties. This is one of the matters we are addressing creatively, in addition to other ways of recognition of the contribution of individuals. It is however noted, that this is also a matter for employers and the system as a whole in recognizing the sustainability of clinical training as highlighted in Draft Proposal 5.3.

Assessment of costs involved in clinical training

The example above of examiners is a cost of clinical specialist medical training which is not explicit, a matter which is also raised in Draft Proposal 5.3. It is possible to quantify a number of direct costs – to an individual trainee (membership fees, examination fees, examination preparation courses), and to an employer (by way of salary).

There are a significant number of implicit costs which are not clear, although this is currently a question which is being explored by the Medical Specialist Training Taskforce. There will be a number of aspects from which those costs will need to be explored including; costs incurred by the employer, costs incurred by the individual, costs incurred by bodies such as specialist medical colleges. These costs may not have been apparent in the past because of complexities in the financing structure of the public health system, in which training has traditionally taken place.

Structure of Training and Regulatory Environments

The single qualification which is awarded by the RANZCR is linked into current state/territory and federal regulatory arrangements. In addition to those relating to

medical registration and MBS billing, in Radiology and Radiation Oncology these also relates to radiation safety legislation.

Traditionally, and at present, the Fellowship of the RANZCR indicates a broad training base within the specialties of Radiology and Radiation Oncology. The development of a competency based framework which is underway, is focused on this broad specialty training. It is expected that many individuals within these specialties may sub or super specialize during the development of their careers. Other practitioners, because of geographic location, or practice environment will continue to practice broadly throughout their careers.

Clinical privileging or credentialling in individual practice environments is necessary as the current regulatory arrangements do not allow a more narrowly defined specialist qualification.

The RANZCR would be unable to give proper consideration to any structural reform, of its training and qualifications procedures until such time as there was clarity from governments about changed regulatory environments, such as may be required if a 'skills escalator' model[13] were introduced, as is discussed in Chapter 5. The notion of a skills escalator is implicitly evident within training programs, in which trainees are given increasing responsibility to practice more independently as their competence improves. The College would be concerned about any suggestions which involved tiered levels of specialty qualification.

Assessment of Overseas Trained Doctors

The Productivity Commission's report refers to a submission from the Committee of Presidents of Medical Colleges [14] in relation to doubts about the sustainability of pro bono training of overseas trained doctors. The RANZCR has also received anecdotal indications that individual doctors are poised to refuse to be a named supervisor/mentor to area of need doctors. This relates to a perception, which appears to be reinforced by comments from some insurers, that this role and responsibility of supervisor/mentor is not one for which they are covered in the normal course of work. This reflects some of the real issues which will continue to require determination at a national level and implementation at a jurisdictional and local level, and would need to be explicitly considered within the scope of Draft Proposal 6.2.

The RANZCR is currently investigating this matter further. It reflects a broader issue in regard to the lack of clarity about the process of both overseas trained doctor and area of need positions. The User's Guide for the Assessment Processes for Area of Need Specialists outlines the manner in which the process ought to operate.

[13] PC report, p. 63
[14] PC Report, p. XLI

There are two aspects of the current Area of Need process which continue to be a source of confusion. The first, relates to the processes within each jurisdiction relating to the initial approval and renewal of Area of Need positions, and the respective roles of Health Departments and the Medical Boards in this regard.

The other matter relates to a lack of clarity as to the responsibilities of various parties in regard to ongoing supervision and assessment of doctors occupying Area of Need positions. As discussed above, this is an emerging issue for some employers and individual supervisors, and has ramifications for other participants in the process including the AMC, the Colleges, the state and territory medical boards, state and territory health departments, the Australian Government Department of Health and Ageing.

This is reflected in the broader issue of legal exposure which the College's face in respect of their activities in these areas. This work is undertaken as part of the profession's responsibility to the community. However, as a not-for-profit membership organization, it is not feasible for this risk to be primarily shouldered by the Colleges.

The College is firm in its position that OTS should be expected to meet the same standard of practice as local graduates. The RANZCR takes most seriously its responsibility in assessing specialist qualifications, which is undertaken in the form of an interview with two senior members of the College, and firmly focused on the capacity of the individual to perform the specialist medical role outlined in the position statement. The capacity of this interview to ascertain other matters assessed 'on the job' such as management skills is limited, and can only be undertaken in the context of performance assessment once an individual has commenced in a position. This is analogous to many of the skills of trainees being assessed in the training environment and not through an examination.

The RANZCR appreciates the support it is presently receiving from the Australian Government Department of Health and Ageing in regard to strengthening its current procedures in regard to the assessment of Area of Need applications. The RANZCR is committed to collaborative relationships, and to engaging constructively in the development of policy. As indicated earlier, it is important that the work currently being undertaken by governments and other stakeholders, through initiatives of the Department of Health and Ageing and the ACCC/AHWOC review, is recognized and incorporated in respect of Draft Proposal 6.2.

References:

1. Siegel Eliot. *Image Information Overload: The Challenge* [power point presentation] 2005 [cited 2005; impact of digital revolution in diagnostic imaging more than in any other specialty].
2. Brealey S et al, *The costs and effects of introducing selectively trained radiographers to an A&E reporting service: a retrospective before and after study.* The British Journal of Radiology, 2005. Vol 78 p. 449-505.