AUSTRALIAN MEDICAL ASSOCIATION RESPONSE TO THE PRODUCTIVITY COMMISSION'S POSITION PAPER ON AUSTRALIA'S HEALTH WORKFORCE

Introductory Comments

The Australian Medical Association (AMA) welcomes the opportunity to comment on the Commission's Position Paper on Australia's Health Workforce. It will come as no surprise that we can identify some areas of agreement and some areas of concern.

The debate needs to be an honest one. The maintenance of quality standards and year-on-year improvements to quality standards cannot be guaranteed as a precondition of the conduct of this report. As a report into health workforce, it must acknowledge workforce is only one aspect of health system performance. Other aspects can and do affect quality such as adequacy of funding etc.

Also, insofar as the report outcomes may lead to an increased rate of substitution by a lesser trained health workforce, a decline in the quality of the health service is a real possibility. Quality cannot be guaranteed by the medical profession if they are not there to ensure it or are held responsible for it with no real connection to the events in question.

It is the Government's choice, if it so wishes, to lower standards to reduce costs. If it does so, it needs to be honest about it and not fail to tell the public what it is doing. It then cannot continue to hold the medical profession responsible for something they no longer control. The difficulty in being honest with the public is that there is no widespread public dissatisfaction with the performance of the medical profession. By and large they get a very high quality service at reasonable cost and with reasonable access, shortages aside.

(a) Quality, safety and access

The AMA welcomes the hope and wish of the Commissioners that the report will maintain a high quality and safe health care system for all Australians.

In recent years, the AMA has witnessed countless examples of government policy failures which have harmed the quality and the safety of the system, including:

- Excessive rationing of access to public hospitals resulting in poor health outcomes for patients in the queues;
- Failure to apply and maintain appropriate standards when recruiting OTDs – with tragic consequences;
- Excessive restriction in public hospital staff numbers resulting in staff burn-out;
- The abject failure of the mental health strategy and the sad loss and wastage of lives as a result of denial of appropriate access to health care;
- Tragic failure to give Aboriginal and Torres Strait Islander people access to appropriate primary health care resulting in high cost tertiary interventions and "fourth world" health

outcomes, related in part to the paucity of opportunities for Aboriginal and Torres Strait Islander people to train as health care workers; and

- Policy-induced shortages of many types of health professionals as governments fail to invest in the development of a skilled workforce.

As you can see, workforce issues are a repetitive theme.

Role substitution is a case in point. Health professionals have a long heritage of working together effectively in team situations to get the best possible outcome for the patient. That happens when each member of the team is engaged to take best advantage of the skills each possesses.

We offer comments later to the effect that the biggest issue in role substitution is that of super-specialisation. However, others seek to give the impression that it is all about midwives versus obstetricians, optometrists versus ophthalmologists or nurses versus GPs. In those circumstances, where the respective skills of all healthcare practitioners have been effectively utilized within a team approach, the goodwill between the professions has allowed changes to occur while retaining safety in the system.

Regrettably, there are examples where paramedical professionals have stepped outside their role and endangered their patients. Every health professional needs to be guided by the fundamental ethic, ***first of all, do no harm***.

Sometimes we hear that the "medical model" of care is the nub of the problem and that other models of care are more appropriate. In childbirth, for example, we know that caesarean rates are much the same whether an obstetrician or a midwife is supervising care. Spontaneous vaginal birth can be a wonderful experience for a mother but were we to insist that every woman deliver that way, neonatal and maternal death rates would both rise to levels that the community would find entirely unacceptable. High quality care in a team situation depends vitally on mutual trust and respect and on each member realising when something is going wrong and taking appropriate steps to retrieve the situation.

Our support for clinical teams is qualified by the need for absolutely clear lines of responsibility to the most senior and experienced clinical practitioner who bears the ultimate responsibility for any decision affecting the heath outcomes for patients. Some clinical situations can deteriorate very rapidly, (particularly in Obstetrics, Surgery, Anaesthetics, Mental Health, Emergency Medicine), and there cannot be uncertainty regarding responsibility nor delay in decision making.

In addition, role delegation is specific to the location of care and the infrastructure support available in the work setting. What is acceptable role delegation in a major teaching hospital with plentiful other professional support may not be appropriate in other situations.

In these introductory comments, we note that if governments want to push the boundaries on role substitution, then they will also be held to account for any reduction in safety and quality. Australia is a wealthy country and it can afford, if it so chooses, to give every citizen access to high quality and safe health care.

It is not enough for the Commission to state the premise, as above, that the report will maintain a high quality and safe health care system for all Australians. It must also show that it has stuck to the plot. In assessing the recommendations contained in the Commission's Position Paper, the AMA has applied a test as to whether or not those recommendations can be reconciled with this objective of maintaining a high quality and safe health care system for all Australians.

In the detailed comments that follow, the AMA has drawn attention to areas where the proposals run a risk, in some cases a significant risk, of impairing the quality and safety of the system. Accordingly, the potentially deleterious outcomes from the proposals are a matter of concern to the profession.

(b) Clinical judgments

In a similar vein, the Commission has emphasised that it was not making any clinical judgments, thereby seeking to distance itself from clinical outcomes. From the AMA's perspective, this does not work. The Commission has made numerous recommendations which risk impairing the quality of clinical training and lowering clinical standards, leading to poorer patient outcomes. The AMA does, of course, acknowledge that the Commission has been constrained both by time and by the limitations in the terms of reference. Ultimately, if the inquiry misfires due to the inadequacy of the reference, the responsibility for that rests with the Government, not the Commission. Nonetheless, to the extent that the AMA has concerns with the recommendations, it must and will raise them.

Far too often, the AMA has witnessed governments talking about delivering better health outcomes through reform when what they are really on about is limiting access to costly services for budgetary reasons. It would seem that doctors are now seen as so costly that other health providers should screen patients to limit access. The actions governments take speak far louder than the things they say. It is, of course, the fate of governments to grapple with those vexing questions of how much tax to extract and where to spend the revenue. However, if the decision is to lower health outcomes for budgetary reasons, then there must be open and honest engagement with the patients and the electorate. If governments are not prepared to meet patient expectations re quality and access, they should say so clearly. Recent problematical events (eg, at Bundaberg) provide perfect examples of the opposite approach of vigorous blame-shifting and the steadfast evasion of the core issues.

The reality is that the advances which deliver better health outcomes rarely come from top-down reforms delivered by government. Rather, they come from bottom up innovation by the health professions and industry. Regardless of what they say, government health policies are not simply determined by a commitment to better health outcomes. Tax dollars are the focus of policy and will be the focus when governments consider the Productivity Commission report into the health workforce.

(c) Professionalism

In the view of the AMA, the Commission has not fully understood the nature of the professions. This misunderstanding does affect the way the recommendations hang together or fall apart as the case may be. The AMA notes that the Commission sees the package of recommendations as an indivisible whole. In that case, to the extent that parts of the proposed system fail, the whole is diminished.

The health professions differ from many other parts of the monetised economy because of the tradition of freely sharing discoveries and the commitment to education. The professions are characterised by an implied contract to serve society over and beyond all specific duty in recognition of the privileges and autonomy society extends to the professions.

In other industries, discoveries are patented and intellectual property jealously guarded. And this is indeed the pattern in the pharmaceutical industry. In stark contrast, the medical profession accepts that it has a responsibility to society at large and patients in particular to share advances in knowledge. The profession would indeed be diminished and its contribution to the greater good would be much less if it did not engage in this cooperative

behaviour. The first step for a doctor making a new discovery is a peer-reviewed article in a scientific journal to share the insight with others.

Likewise the medical profession as a whole has a commitment to excellence in education and training. There are, of course, those who will accuse the profession of seeking to run a closed shop and who will attack any profession that enjoys some autonomy. The AMA notes that these debates will go on, indeed as they should, but it is a measure of autonomy that drives considerably to the greater good. This response to the Commission is not the time or the place to engage on this issue.

For the most part, the Commission has acknowledged the importance of pro bono work in postgraduate training. From the viewpoint of the profession, the challenge of how to raise standards and improve the quality of outcomes is absolutely vital. There is always room for improvement and cooperative behaviour is a positive force in these endeavours. The Commission's emphasis on contestability of training is built on simplistic economic theories which do not acknowledge the existence or the benefit of cooperative behaviour within the professions. The AMA holds that there are distinct advantages in a mixture of academic and professional training. The Commission has failed to see the connections between changes in governance which may have the effect of removing or reducing professional autonomy and the generous provision of professional expertise and time required to maintain standards and accreditation, including the activity of the accreditation agencies and state based Professional Boards.

The accessing of health care is different to other purchasing decisions. Educating patients sufficiently for them to make wise decisions about their health care is an important part of the professional service. In some situations, the requirement for professional leadership is even stronger and the consequences too serious to leave the matter solely in the hands of the patient.

(d) Efficiency and effectiveness of delivering health outcomes

Many of the proposals in the Position Paper are predicated on achieving efficiency gains in the delivery of health care. The AMA notes that there is a huge amount that could be done to improve the effectiveness of the existing health workforce by the provision of better work processes and support within the current services systems. These would include better IT and reduced red tape.

(e) Clinical research

A highly trained and motivated workforce able to engage in teaching and research in a conducive environment is the backbone of the health system. Clinical research lies at the heart of progress to lift quality and safety. Medical education and training fosters a commitment to lifelong learning which must be supported in the workplace. The scientific and intellectual rigour that goes with this discipline is the only sure way of ensuring valid and safe advances in care. No amount of workforce policy reform will prevent Australia's health system falling behind comparable countries if the national commitment to clinical research weakens. While the terms of reference for the inquiry do not explicitly address these issues, the AMA considers them to be germane to its underlying aims.

(f) Workforce retention/retraining

Our final introductory comment is to warmly welcome the indication from the Commissioners that the final report will give greater emphasis to retention issues. The lack of attention to retention issues is a large gap in the Position Paper. The AMA notes that while retention issues will feature prominently in public policy for as long as the current shortages of health

professionals persist, they are a valid element of the medium to longer term framework as well. It would be a mistake of judgment to regard retention issues as short term only. Health professionals are a costly resource and no society is so wealthy it can cheerfully waste its costly resources.

More than 30% of General Practitioners are aged 55 or over and the figures are not too dissimilar for specialists. Any sudden loss of these practitioners would be disastrous for the health system. They are hard working and the most experienced practitioners and it takes 1.6 new medical practitioners to replace each departing one. Attention to this matter is urgent in our view.

(A) Workforce self-sufficiency

For many years, Australian governments have relied heavily on recruiting overseas trained health professionals in the naive belief that this was a cheaper and quicker way to meet workforce needs than training the numbers needed for self-sufficiency. For this to be a sustainable solution, it did mean either that other countries had to be over-producing health professionals or that the wealthier countries pursued the unethical path of simply depriving the poorer countries of their health professionals. We can say with authority that the OTD/TRD solution has not solved the shortages of doctors in Australia and it is our observation that similar strategies have been no more successful in solving the shortages of other health professionals. In fact the deficit in access to skilled health professionals is a global phenomenon.

One obvious reason for the failure of the strategy is that many other countries have copied each other (the USA, the UK, Canada, Ireland, New Zealand, South Africa, etc). In short, we have too many borrowers and not enough lenders.

Australia has a high quality health education system and it is a net exporter of health education services. We ought not lose the irony of a wealthy little nation busily exporting health education services but complaining that it cannot afford to train enough health professionals to meet the health needs of its own citizens!

The AMA endorses the concept of self-sufficiency of the health workforce and endorses several initiatives to achieve this end including making part time work attractive for older medical practitioners and capitalising on the potential to use private hospitals and residential aged care facilities as training grounds. It notes, however, that governments and the health professions will have to come to terms with the evolution of international labour markets and increasing labour mobility across national boundaries. In short, countries will have to accept that they have mutual obligations to their people and to each other to ensure that each pulls on their oar in educating and training health professionals. Self-sufficiency in a vacuum is unattainable. We are not in a vacuum.

We ought not try to erect fences to keep the Australian doctors within Australia and the overseas doctors out. It is not a sensible proposition and runs directly counter to every observed trend. There are considerable mutual benefits from international experience in skills transfer. Australian trainees benefit from overseas training and work experience to round out their skills and education. Similarly, overseas trained doctors benefit from being exposed to clinical training and work in Australia. Australia cannot be an island or be seen as unco-operative in an increasingly international medical workforce environment.

One ongoing issue is, however, the maintenance of Australia's high clinical standards with a view to maintaining quality, safety and access (linking again to a key premise adopted by the Commission in preparing the Position Paper). That can be achieved but it requires a purposeful approach. There is a critical need to introduce transparent national processes to

ensure that overseas trained doctors are properly assessed and given access to sound support, training and supervision.

Another ongoing issue is that of workforce retention. The ultimate result of the emergence of a world labour market is a world price for labour. Likewise, terms and conditions of employment including remuneration have to be competitive if we wish to attract enough health professionals to meet the needs and expectations of the people.

The Australian government has already saved very substantially by marketing to overseas doctor populations. As a short to medium-term solution the government should reinvest some of these savings in the upskilling and training of overseas trained graduates resident in Australia who are so far not able to return to the health care workforce. Get doctors out of taxis!

(B) Facilitating workplace innovation

(B1) Establish an advisory health workforce improvement agency

The AMA supports the recommendation for an advisory health workforce improvement agency and strongly advocates medical profession involvement in such a body. As noted above, most innovative ideas emerge from the "bottom up" rather than the "top down". An advisory agency could be the lightning rod for improving understanding of these innovations, how they might be propagated more widely and, importantly, understanding why an innovation which worked well in one professional and/or geographic area failed to light the fires in another. The advisory agency would not have to generate all the ideas itself. It can play a facilitation role and identify the roadblocks to innovation (many of which, no doubt, will reside within the Commonwealth/State imbroglio).

(C) More responsive education and training arrangements

(C1) Primary responsibility from DEST to DoHA

The AMA's reaction to this proposal is that education and training should not be considered a single entity as while they are linked in the final outcome they have very different costs and providers. DEST has the greater expertise in education while DoHA has the greater expertise in training. Therefore, on the basis of horses for courses, the AMA sees no strong case to shift the primary responsibility. Our concern is that regardless of who steers the ship, navigation aids clearly indicate what the needs are so that they are given proper weight. Liaison between the two entities must be maintained to allow the system to calibrate its response to workforce issues in the most appropriate fashion.

The universities have had considerable autonomy in determining undergraduate and postgraduate places and no doubt will be reluctant to cede this autonomy. They do not have a proud record of producing the numbers of graduates needed and commonly overshoot (too many, too few). Then again, governments cannot point to any superior record in workforce planning. The AMA does not see the lack of coordination as the greatest problem. Rather, it is the fact that the various players have not had access to high quality information to underpin their decisions. In a context of rapidly changing health technologies, estimating the number of graduates that might be required in future is a hazardous task but it is not a discretionary one. Australia can and should lift its game in this area and make sure that all key decision makers have access to high quality and relevant information.

(C2) Establish an advisory health workforce education and training council

The AMA supports this recommendation but remains concerned at the proliferation of committees, especially those under the umbrellas of COAG and AHMAC. Any decision to create an advisory body of this nature ought to be taken with an eye to abolishing some others so that the health system is not subject to an endless, process focussed, committee-led oblivion. Advisory bodies play a very valuable role in the Australian health care system. They give decision makers access to expert advice which opens the potential for better informed, high quality decisions. They do not require decision makers to cede their responsibilities to others. At times, however, decision makers can be observed setting up parallel processes in the pretence of getting alternative advice. If enough bodies are established, there's sure to be one to endorse Departmental policy no matter how misguided. The scattergun approach dilutes the value of advisory bodies. A hierarchical approach creates a different but all too familiar set of problems.

Clarity in the respective roles and objectives of the advisory health workforce improvement agency and the advisory health workforce education and training council is both necessary and achievable.

It should not be assumed that these initiatives will always lead to more desirable patient outcomes reached through more democratic and representative decision making. Where these models do exist at State and Territory levels, they have sometimes limited the input of consumers and doctors to the point where inferior outcomes are produced.

(C3) Improve understanding of operation of system and enhance transparency and contestability of funding frameworks

The AMA expects that improved understanding of the education and training system will lead almost certainly to its retention. The current system has some explicit payments, some implicit payments and some elements of barter (registrars accepting low wages as a tradeoff for receiving training). Once the true cost of the system is known, it will be no easy task to persuade governments to fund it explicitly.

Explicit funding (unbundling of training from clinical roles) is a high risk strategy. It would inevitably add to costs on both purchasers and providers as there would be additional transaction costs not present in the system (both as to payments and acquittal of funding received).

Over and above that, explicit funding means yet another program to be administered (on top of the 600 or so that exist now). Within DoHA, departmental costs of administering programs range up to 30% of administered funds (funds actually applied to the program). One might hope that explicit funding would not add 30% to the cost but experience tells us it is within the range of probabilities.

If implemented (contestability), the risk is that it will be seriously under-funded with a deleterious impact on professional standards, quality and safety of care, access to care and patient outcomes. These objectives remain fundamental as is the pre-requisite of providing sufficient resources to allow the health care system to run appropriately. In addition, there has not been enough recognition of the interconnectedness of training programs and the workplace in which that training is delivered. Unbundling the two may weaken that association and therefore lower standards. You separate pilot training from the planes in which they fly only at the cost of producing inferior pilots and the same is true of medical training.

With reference to our comments in the preamble, competition for the delivery of training is based on simplistic economic theories which do not acknowledge the existence or importance of cooperative behaviour among medical and other health professionals.

Efforts to transpose competitive models in sparsely populated countries like Australia have a history of null outcomes because the markets are not large enough to sustain many players. Even in densely populated areas, governments have made a farce of managed competition within health care delivery because the markets are not truly contestable and may never be under governments of some persuasions.

The AMA does not accept the Productivity Commission's analysis or conclusions in this area. It comes down to understandings of what we have now and the potential for competition policy to make a material difference. The AMA does not accept that the current system is unsustainable. Of course, we are faced with other choices and opportunities about where training is provided. If governments continue to maladminister the public hospital system and do not allow the senior consultants time for training purposes, it is inevitable and sensible that there will be increased dialogue with the private system. At present, private teaching hospitals are the exception because the financing system does not accommodate it.

(D) A consolidated national accreditation regime

(D1) A single consolidated national accreditation agency for University-based education and training and postgraduate training

The AMA does not support this recommendation. During the Canberra consultation, the Commissioners affirmed their confidence in the AMC and the way it engages requisite expertise. However, we are given to understand that it sees the AMC model as "too medical" and that it proposes the development of a new model of a single agency with a broader commission.

It was clear from the discussion at the Canberra consultation that some of the health professions would benefit from a national approach to accreditation. Few, however, expressed much interest in a single agency.

The Commission has sought to portray this merely as an issue of governance with expertise bought in as required. For its part, the AMA does not believe that separating governance and expertise is feasible. Health professional groups and individuals have considerable investment in professional autonomy and individuality. While it was denied there can be little doubt that the result, even if not the intended outcome, of national consolidation of accreditation will be the homogenisation of the health profession with the consequent disengagement of professional groups in the provision of the expertise required for appropriate standards setting.

The usual argument for a cross-professions approach is that if they are left in their "silos", they will not work together. We find this oxymoronic. If the professions won't work together, a change in governance will not alter that. In fact, the health professions have shown that they can work together. In addition, it is the AMA's view that the profession-specific accreditation bodies are needed to engage the necessary level of expertise and that this expertise will be lost if the professions are denied "ownership".

The Commission has an interest in the potential for cross professional workforce development and there is little doubt in our minds that this interest has helped set the sails for a single accreditation agency. Much of the need for workforce development can be led by the advisory health workforce improvement agency so protecting the professional role in accreditation standards and protecting the public. The history of role substitution for the

medical profession is primarily (90%) one of super-specialisation with specialists taking roles from GPs. Perhaps only 10% of the issues relate to the interface between medical professionals and other health professionals. Most recently, GPs have enthusiastically embraced the concept of practice nurses and are making the system work.

Were the Government inclined to support the idea of an over-arching accreditation agency, then the AMA would consider it imperative that the new agency adopt the fire-hardened principles which now guide AMC processes.

In relation to the recognition of a specialty, the AMC considers applications against three core criteria:

(a) that recognition of the medical specialty or sub-specialty will improve the safety of health care;

(b) that recognition of the area of medical practice as a specialty or sub-specialty will or is likely to improve the standards of health care and that the data, where available, demonstrate better outcomes; and

(c) that recognition of the medical specialty or sub-specialty will result in cost-effective health care and/or that the community benefits justify the increased costs of health care.[1]

In a similar vein in relation to the recognition of training programs, the recognition process proposed by the AMC aims to assure the community:

(a) that the new area is developing in response to a need for specialist medical expertise and that it will contribute to improved standards of health care;

(b) that the new medical specialty or sub-specialty is based on sound clinical and scientific principles;

(c) that underpinning the practice of the specialty or sub-specialty is a group of practitioners with the mission and the capacity to define, promote and maintain standards of medical practice that will ensure high quality health care that uses available health care resources wisely;

(d) that practitioners of the specialty or sub-specialty are appropriately trained in the knowledge, skills and attitudes required for safe and competent practice, and are participating in accredited continuing professional development programs to maintain their standard of practice; and

(e) that on balance the benefits of the development will outweigh any costs/adverse effects on other aspects of health care delivery.[2]

With appropriate broadening of the language, these principles should apply to all health professions including newly emerging health professions.

(E) Supporting changes to registration arrangements

(E1) National uniform registration standards based on the work of the proposed national accreditation agency, etc.

The Productivity Commission has not recognised the important role of the Registration Boards (regardless of profession) in the consideration of disciplinary matters against a member of the profession through misconduct or incompetence. The Boards also have to

1 The Recognition of Medical Specialties and Sub-Specialties: Policy and Process, AMC, 2004

2 Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures, AMC, 2003

deal with impaired practitioners. This is in addition to their important role of ensuring that health professionals are registered, that their qualifications are verified and appropriate restrictions to practice are implemented where necessary.

The AMA supports enabling all registration boards to fulfil these roles in a high quality manner and with uniform processes. The AMA supports a move towards more effective national registration arrangements for the medical profession and notes that this is occurring already.

The AMA does not support a single registration board covering all health professions.

The AMA does not support restrictive forms of registration and accreditation which control all aspects of professional practice. There already exist multiple levels of regulation at the hospital and specialist professional level. There is a risk of duplication of regulatory bodies and systems if the Government imposes further regulation. The Productivity Commission may not even be aware of the extent of this current regulation and the potential for its recommendations to further reduce the attractiveness of clinical practice.

(F) Improving funding-related incentives for workplace change

(F1) Independent review body (subsuming existing committees) to advise on services to be covered by the MBS, etc

As things stand, the MBS is substantially under-funded for its current role. The current (albeit undeclared) policy is to chase the bulk-billing targets for low priced services only and to shift the costs of high priced in-hospital services to the PHI funds via their gap insurance products. As noted earlier, it is the fate of governments to grapple with those vexing questions of how much tax to extract and where to spend the revenue.

The Commonwealth government is expressing increasing concern about its ability to fund health services for a rapidly ageing population. It is doing something about it by effectively de-nationalising elements of Medicare to private health insurance. Against this background, the Commission is proposing that areas now quite adequately covered by PHI be covered instead (or, perhaps, as well) by Medicare (ie, that these elements of health insurance be nationalised). Given scarce funds, what does that imply? Further elements of Medicare would have to be de-nationalised to make room for the newly nationalised components.

There is in no doubt that the MBS has a considerable impact on medical workforce. Ever since the sinking of the Relative Value Study (RVS), consultative practice has been lagging behind procedural practice with declining numbers of renal, thoracic and rheumatology specialists and no growth in the specialties of geriatric medicine and rehabilitation so essential to an ageing population. Addressing this disparity with the MBS could effectively redress this.

The Position Paper does not display a proper understanding of the fundamental differences between PBAC and MSAC/MBCC. MBS benefits are payments to patients with the amount of the benefit reflecting the amount the Government is prepared to chip in to help the patient get access. Benefits are not related to the costs of producing the services in any systematic manner and range down to as little as 30% of the market price.

In very stark contrast, the Government acts as a monopsony purchaser for all prescription drugs. PBAC's role is to help the Government decide on its highest priorities if, and when, it has any more money available for the PBS. PBAC does not have a role until the TGA has first assessed a drug as safe, whereas MSAC's role is to make those evidence-based assessments about the safety and effectiveness of new procedures, as well as to address

the economic and financial issues. The economic models within the PBAC to establish cost effectiveness cannot be translated to a model where the item purchased is a service with a wider number of variables.

From the viewpoint of the medical profession, MSAC and MBCC appropriately engage medical expertise whereas wider-spaced advisory bodies may not. Nothing will change the cold, hard reality that governments have limited funds to spend and that the medical profession will express dissatisfaction with the final Ministerial approvals. But there is a significant risk that the quality of advice will decline when advisory bodies are broadened. The depth of experience and expertise is valuable. The AMA would prefer to see MSAC and MBCC retained.

Making MSAC and MBCC subsidiary committees in a deeper hierarchy will only add to delays and inefficiencies. A cursory inspection of the records of these committees will indicate that the applications before them are not prone to claims for substitution or like matters and they basically need not be disturbed. They already stretch the limits of responsiveness to patient needs and to jeopardise that further would be irresponsible.

(F2) Discounted rebates for a wider range of services

Our comments here follow on from what we have said about pushing some things out of Medicare while pulling other things in. From where the AMA sits, it boils down to fooling around with patient co-contributions (up in some areas, down in others) but has little to do with improving workforce efficiency and enhancing outcomes for patients.

As we noted above, GPs have enthusiastically embraced the concept of practice nurses and are making that system work. That initiative was an appropriate response to a serious shortage of GPs. It has helped the primary health care workforce meet patient needs in a cost effective manner.

Rebates for delegated services need to be set at levels which provide the appropriate incentives. If the discount is too deep, it will not be economic for the services to be provided. Hence there will be no delegation and no savings.

(G) Better focussed and more streamlined projections of future workforce requirements

(G1) Concentrate formal projections on the key workforce groups. Undertake scenario analysis as a matter of course.

The AMA is comfortable with the recommendation and supportive of the stated intention of the Commissioners to look further into productivity issues. Projections which assume no gains in productivity have no credibility but there is no credibility, either, in overstating the potential for productivity gains. It is important that there be a keen appreciation of the differences in scope for productivity gains between the consultation work and the procedures.

Some major gains in productivity in health care have come about as a result of a paradigm change in the way care is delivered, for example, a new drug which is more cost-effective and produces better outcomes than a surgical alternative. The difficulty of predicting where these technological changes might appear bedevils detailed workforce projections.

(G2) Rationalise structure through abolition of AMWAC and AHWAC.

The AMA agrees that the current institutional structure is cumbersome but the Commission has found the wrong targets. The problem doesn't rest at the ground level (AMWAC and AHWAC). Rather, it rests in the many layers superimposed above those two bodies, with a labyrinth of committees by which advice is progressively sanitised for the easy consumption of Ministers. The AMA cannot see merit in subsuming the two bodies into one.

AMWAC has been recently reviewed and reconfirmed. It does have a mixed track record (generally speaking, having made more sense of specialty areas than general practice) but there can be no doubt whatsoever that it has been a party to the nurturing of a science and a discipline (AIHW has been a key partner and played a key role in informing workforce issues). AMWAC is light years ahead of the chaotic ad hoc and ill-disciplined handling of workforce issues over the 1960s, 1970s and 1980s.

The AMA remains of the view that AMWAC is a potentially useful mechanism for engaging specialty-specific expertise and that, with greater rigor in its methodologies (especially its quantitative work), it can make further progress in lifting its game of workforce projections. The AMA does not accept the argument that there has been undue professional influence in its processes, more the contrary.

(H) More effective approaches to improving outcomes in rural and remote areas

(H1) All system-wide frameworks in the health workforce area to make explicit provision for consideration of rural and remote issues

The AMA supports the recommendation as a necessary, but not sufficient, solution.. To resolve rural health workforce issues, governments need to pay attention also to the infrastructure required to support the delivery of rural health care. We note that:

- There seems to be broad acknowledgement amongst stakeholders that rural doctors in many areas are required to undertake more procedural work with limited access to support. There is also a strong push to place more junior doctors in rural areas as part of their training programs; yet
- The closure of rural hospitals and the limitations in the services the remaining hospitals can provide, the withdrawal of specialist services in rural areas and the lack of opportunities to gain hands-on experience in the latest procedural techniques are destroying the environment so crucial to the maintenance of procedural skills.
- Junior doctors working in rural areas are often given little or no supervision and are used simply for service delivery. The lack of infrastructure and support can turn a potentially positive experience into one that discourages the junior doctor from any further interest in rural practice. Governments must ensure that junior doctors are placed in an environment that is conducive to a strong learning experience. Supervision, infrastructure, and support must be the essential elements of any drive to get more junior doctors into rural areas.
- Consideration needs to be given to broader social issues in rural areas. The doctor is only part of the equation - employment, education and other opportunities for doctor's family cannot be ignored.

(H2) Initiate a cross-program evaluation exercise

The AMA supports this recommendation.

It ought not be acceptable to Australians that people in rural and remote areas have less access to services and poorer health outcomes than those in urban areas. We should be seeking service excellence in all geographic areas. Unit costs are undoubtedly related to the frequency of services provided so lower volume rural practice faces a cost disadvantage. The funding of rural health services needs to reflect this reality. Governments should ensure when services cannot be provided proximally, patient access is not denied for logistic or financial reasons.

Much of the disparity between rural/remote and urban areas is due to the limited access to services and appalling health outcomes of Australia's Aboriginal and Torres Strait Islander peoples (see next section).

These problems are famously difficult to resolve. More than a decade of Federal programs to support access in rural and remote areas has likely prevented a widening gap but does not appear to have closed the gap in any material way. Other countries with similar geographic challenges appear to have had no more success (or little more) than Australia. Fresh thinking is required, but it is important also that we get a full understanding of the successes (eg extension services) and build on them.

(I) Ensuring that the requirements of groups with special needs are met

(I1) All broad institutional frameworks to make explicit provision to consider the needs of these groups

The AMA supports this recommendation.

The two special needs groups most neglected in the current allocation of resources are Aboriginal and Torres Strait Islander people and Australians with mental health problems. In this context, "resources" should be read widely as a reference to funding, institutions and workforce.

The AMA would like to see many more Aboriginal and Torres Strait Islander people encouraged and supported to train as health professionals. The extreme under-representation of Aboriginal and Torres Strait Islander people among health professionals stands as one barometer of the overall disadvantage they face in Australian society, disadvantage which reflects in their health status. These issues are addressed in some detail in successive AMA Aboriginal and Torres Strait Islander Health Report Cards.

Likewise, mental health care will remain below par where the workforce and the access to institutions (when required) are both so far short of needs. These issues are addressed in some detail in the AMA's submission to the current Senate inquiry on mental health.

Closing Comments

The AMA urges the Commission to rethink its "de-medicalisation" of every element of the health care system. The basic premise for the AMA is maintaining a high quality and safe health care system for all Australians. Australians have come to expect and indeed demand high quality health care from their medical practitioner. Are we prepared to lower the cross bar for them? Would the community regard this as maintaining a high quality and safe health care system? We think not.

All the health professions can be a powerful benefit to the community. It is important to keep them engaged in constructive processes with the common aim of improving health outcomes. Medical practitioners have a long and proud record of cooperative behaviour for the wider benefit of society. Their expertise is a national asset not to be wasted.

Australian Medical Association
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