**Response to the Productivity Commission Position Paper**
***"Australia's Health Workforce"***

## Overview

The Royal Australasian College of Surgeons (the College) is concerned that the main focus of recommendations in the Productivity Commission paper is forming committees and, for what was a "research study of the health workforce", there is a paucity of hard evidence on which comment is based.

The College believes that creating a series of agencies and councils avoids the implementation of important efficiencies that can be gained immediately. As pointed out in the College submission (No 148) these include:

- better workplace arrangements in public hospitals to ensure greater use of operating theatres,
- better strategies to address same day cancellation of patients, and
- better funding to keep public hospital operating theatres open more days of the year, and to improve and maximize utilization of surgeons currently employed in public hospitals.

There is not enough money in the public hospital system and College members feel any new money that is injected only goes to feed an ever burgeoning bureaucracy. Further that bureaucracy often lacks the human resource management skills to retain its public sector surgical workforce who always have the option to move to the private sector.

Surgeons who remain in the public hospital system cannot operate productively because of constant budget restraints and bed closures. Surgical training in the public system is being compromised as a result of reductions in the number and complexity of operations performed with recent evidence showing movement of surgeons out of the public system.

If we wait for committees to address other important issues like funding for more Specialist Surgical Training (SST) places, the through put of trained surgeons will fall further behind.

The recent Forster Report in Queensland emphasized the need to involve clinicians in the reform process so if new structures are created the College believes they should be independent statutory authorities, have significant medical involvement on their boards and be adequately funded by government.

To achieve solutions, the public system bureaucracy needs to be lean and efficient and focused on health outcomes.

In response to the specific recommendations made in the paper the College offers the following comments.

**The National Health Workforce Strategic Framework**
Draft Proposal 3.1
*In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.*

The College has concerns at any move away from a policy of self sufficiency for Australia's surgical workforce. There is an international shortage of suitably qualified surgeons and Australia should be training more surgeons to alleviate its own and even make a positive contribute to solving that shortage. The assessment procedures for IMGs are already complex and will only get more so if, in response to the world wide shortage, lesser quality IMGs are attempted to be recruited.

**Facilitating workplace change and job innovation**
Draft Proposal 4.1
*"The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.*

- *Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience."*

The College is concerned that in attempting to balance the competing interests in creating an "appropriate" membership, compromise selections will result rather than the choice of the best people for the task.

The College considers that creating such a body will only raise expectations among key stakeholder groups that "solutions" will come from this body and stifle necessary reform that must occur in public hospitals. An advisory body has the potential to be highly politicized and has no ability to implement any of its recommendations. As a result such bodies have a history of focusing on the easy and least offensive changes but not tackling the really hard issues.

The health system needs better funding and significant workplace reform in public hospitals. Unless that happens, extra surgeons will not result in greater volumes of public hospital surgical services.

If an advisory health workforce improvement agency were to be created the College believes it should have significant medical involvement on its board and be adequately funded by government.

**Making education and training more responsive to changing care needs**

Draft Proposal 5.2

*The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:*

- *opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and*
- *their implications for courses and curricula, accreditation requirements and the like*

Draft Proposal 5.3.

*To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:*

- *improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;*
- *examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;*
- *better linking training subsidies to the wider public benefits of having a well trained health workforce; and*
- *addressing any regulatory impediments to competition in the delivery of clinical training services.*

The College is concerned that draft recommendation 5.2 suggests new workforces or task delegations with no evidence to suggest that increased productivity may actually occur. It suggests new training but fails to comment on the new productivity required first to sustain more training. It proposes drawing people out of existing workforces to do higher level delegated or substituted tasks but fails to address basic issues of recruitment and retention to enable backfilling of the workforce gaps created in the major engine room of our health system.

An advisory body must have adequate medical input to ensure solutions are medically valid and uphold professional standards. Unless those on these committees are nominees of the organization then as advisory bodies they have little ability to influence change and their establishment will inevitably delay reforms that need to be implemented now.

The good teaching, good research and community service provided by the surgeons who work in public teaching hospitals should also be valued.

If an advisory health workforce education and training council were to be created the College believes it should have significant medical involvement on its board and be adequately funded by government.

The College is broadly supportive of recommendation 5.3 provided such moves ensure the contribution surgeons make to education and training (especially the value of their pro bono contribution) is independently measured and publicly acknowledged.

**An integrated approach to accreditation**

Draft Proposal 6.1

*The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.*

- *It would develop uniform national standards upon which professional registration would be based.*
- *Its implementation should be in a considered and staged manner.*

The College believes the existing Australian Medical Council (AMC) and Australian Competition and Consumer Commission (ACCC) provide more than adequate protection for consumers of surgical services.

The College does not believe a new accreditation body to oversee the AMC should be established. In fact the AMC's role should be enhanced to include the accreditation of training undertaken by any provider who professes to offer services equivalent to any surgical service. (i.e. those offering task substitution).

The College has concerns that the claims of "dermasurgeons", "cosmetic surgeons" and "podiatric surgeons", who have not undertaken comprehensive surgical training to a substantively comparable standard of that of a Fellow of the College, need to be assessed by an independent body. The AMC has the experience and credibility to assess such claims.

The College considers that "task substitution" is inherently problematic and that 'task delegation' within the context of a professional clinical team is a more appropriate approach. It should not be sufficient for groups to just claim they are able to provide the same or better services. Their claims and any evidence need to be independently assessed, otherwise standards will be compromised.

Where task substitution occurs then outcomes should be entered into a database and assessed for all providers. This would require adequate funding and resources.

Draft Proposal 6.2
*The new national accreditation body should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment process, recognition of overseas training courses, and the criteria for practise in different work settings.*

The College supports a national approach to assessment of overseas trained health professionals. However, this is a complex and costly process as has been demonstrated by the Colleges review of assessing its IMGs.

**Supporting changes to registration arrangements**
Draft Proposal 7.1
*Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.*

Draft Proposal 7.2
*States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.*

Draft Proposal 7.3
*Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.*

The College supports a nationally consistent and transportable registration system based on uniform standards. Those standards should be uniform across jurisdictions and importantly across providers for all services that are claimed to be equivalent.

The uniformity of standards is essential for services provided by "podiatric surgeons" and medical practitioners who claim their services are equivalent to (and therefore can substitute for) those provided by trained surgeons. All equivalent services should have the evidence for such claims and their training assessed by an independent body such as the Australian Medical Council. It would be completely unacceptable to the College if the medical profession undergoes stringent assessment while other groups claiming equivalency of their services, such as "podiatric surgeons" avoid the same process.

Currently, medical specialists are registered as such in Queensland and South Australia. This process should be introduced nationally to ensure adequate standards of training and maintenance of skills.

Uniform standards and national consistency are especially important for International Medical Graduates who form the large bulk of doctors moving to rural and remote areas to work as general practitioners and for new surgeons moving to regional hospitals and areas of need. Such a process might very well have avoided the recent distressing events in Bundaberg.

**Modify funding and payment mechanisms to improve incentives**
Draft Proposal 8.2
*For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:*

- *the service would be billed in the name of the delegating practitioner; and*
- *rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.*

*This change should be introduced progressively and its impacts reviewed after three years.*

The College is broadly supportive of task delegation as outlined in the Commission's paper. It is already used in general practice and would allow greater efficiencies in many surgical groups. If the medico legal burden is to remain primarily with the delegating doctor then it must only happen with the express wish and supervision of that doctor.

**Improving numerical projections of future workforce requirements**
Draft Proposal 9.1
*Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.*

Amalgamation of existing bodies must only occur if it improves and builds on the work groups such as the AHWAC and AMWAC have undertaken. The major issue for the College is the political interference that occurs no matter what workforce projections are devised. Whether the National Health Workforce Secretariat predicts future workforce needs using a scenarios-based approach or other techniques one thing is certain, jurisdictions will continue to make political decisions when adjusting workforce levers, rather than objective decisions based on evidence.

**Rural and Remote areas and those with special needs.**

Draft Proposal 10.1

*The Australian Health Minister's Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.*

Draft Proposal 10.2

*The brief for the health workforce improvement agency (se draft proposal 4.1) should include a requirement for the agency to:*

- *assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and*
- *as appropriate, consider major job redesign opportunities specific to rural and remote areas.*

The College supports draft proposals 10.1 and 10.2 provided there is direct input to decision making by surgeons.

The College believes the statement that "there are limits on the degree of improvement in access to services possible in rural and remote areas" (page 169 of the paper) is too defeatist. Financial incentives and recruitment programs for general practitioners to move to rural and remote areas appear to be having some success and similar schemes could be instituted for surgeons.

Surgical services can be provided to rural and remote areas but it requires adequate infrastructure funding and cooperative workforce solutions. Often those solutions require funding from state governments who are guilty of closing regional services on the basis of cost cutting. Surgeons can be attracted to rural and regional Australia if they are provided with proper funding, appropriate infrastructure, after hours rosters and locums. If these had been provided we would have enough surgeons and not need "innovative" substitution by less trained non-medical providers.

The College will continue its work trying to improve delivery of services to rural and remote areas, indigenous Australians and those with special needs.

**Limitations of the Study**

The College believes that the study's limited Terms of Reference have significantly comprised the Commission's ability to provide solutions for a complex problem. Surgical workforce solutions in metropolitan and regional areas must address issues such as under resourcing in the public hospital system, under utilization of surgeons (productivity) and limitation of services and training opportunities created by budget constraints. The adverse affects of budget restraints are further compounded by an unsupportive administrative culture that has lost surgeons from the public hospital workforce and a failure to reform a top heavy inefficient bureaucracy.