ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SENATE INQUIRY INTO HEALTH POLICY, ADMINISTRATION & EXPENDITURE

COMMONWEALTH GOVERNMENT

SEPTEMBER 2015

EXECUTIVE SUMMARY

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical education, training, and high standards of practice in Australia and New Zealand. RACS is the trusted and acknowledged authority on surgery, and our Fellows and staff work closely with other health organisations to promote the best health outcomes for patients and the community more broadly.

Hospitals and healthcare providers across Australia are facing an increasing demand for services. Overall funding for health has increased throughout the past decade; however the cost of delivering healthcare has also increased, together with public expectations about acceptable standards of care and provision of health treatments.

RACS has established a Sustainability in Healthcare Committee to guide its advice to government to ensure standards in healthcare are maintained in a fiscally responsible manner. We have reviewed our position papers on informed consent and informed financial consent; published a position paper on excessive fees which states our opposition to exploitative and unethical fees; and encouraged our members to exercise full disclosure and transparency about fees when dealing with patients.[1] RACS is in ongoing discussions with health insurers, government and other key stakeholders on the issues facing the sustainability of healthcare. The RACS approach is guided by a patient-centred ethos that gives consideration to the full effect of reform measures on patient care and service provision across metropolitan, rural and remote Australia.

In all states and territories, wait times for elective surgery continue to be a concern for surgeons and patients. Of those who saw a medical specialist in 2013-14, one in four people waited longer than they felt acceptable to get an appointment with a medical specialist.[2] Meanwhile the proportion of total health expenditure provided to the public health system in Australia in 2013 decreased to 66.4%.[3] This is the lowest proportion of total health expenditure provided to the public system since 2003. By comparison, Canada allocated 69.8%, New Zealand 83%, and the UK 83.5%.[4] It is vitally important that the Commonwealth, state and territory governments continue to examine and, where necessary, realign funding priorities to ensure that healthcare is sustainable.

Within the inquiry's terms of reference are highlighted some key areas of concern, which we believe have the potential to impact on the sustainability of Australia's healthcare system, and the provision of surgical services in particular. These issues include healthcare funding arrangements, Medicare reimbursement rates, preventative health measures, the impact of obesity, alcohol-related harm and tobacco on Australian health, end of life care, Indigenous and rural health, scope of practice and workplace issues such as training hours.

THE IMPACT OF REDUCED COMMONWEALTH FUNDING FOR HOSPITAL AND OTHER HEALTH SERVICES PROVIDED BY STATE AND TERRITORY GOVERNMENTS, IN PARTICULAR, THE IMPACT ON ELECTIVE SURGERY AND EMERENCY DEPARTMENT WAITING TIMES, HOSPITAL BED NUMBERS, OTHER HOSPITAL RELATED CARE AND COST SHIFTING

Waiting lists

In the past, funding has been dedicated to improving waiting times for elective surgery, but often targets for elective surgery waiting times have been met by deferring patients from attending an outpatient clinic. Any meaningful action to reduce wait times must address both the elective and outpatient lists cohesively and transparently, with clear criteria for assessing urgency for an outpatient assessment, and clear guidelines for categorisation once a decision has been made as to the need for surgery. An outpatient appointment should be seen as an appointment to either receive a date for surgery, or be told that surgery is not required.

Inappropriate delays in accessing surgical assessment can be associated with increased risk of morbidity and mortality, and may increase the cumulative impact of degenerative diseases on an ageing population, health outcomes and service demand. Patients must then have ready access to appropriately trained staff for clinical management, as it is the role of the surgeon to ascertain the

most appropriate treatment for the individual patient, and plan that treatment in conjunction with the patient and their carers.

The level of funding to enable the profession to collect data for research purposes on surgical procedures and outcomes has historically been much lower than the funding and time provided to other areas of medicine. Appropriate clinical data collection is critical for determining patient flows and health care outcomes. It is difficult to ascertain accurately what the structures and needs of a refined and improved planning and scheduling system would look like without research funding being made available to conduct this research.

RACS recognises that general practitioners and other non-surgical specialists require timely access to specialist surgical assessment and care for patients who require surgical review. It is important that primary practitioners are able to adequately triage patients; but to enable them to do this properly, guidelines with respect to information required and investigations performed need to be developed. A review of the referral process and efforts to improve understanding of what is required is essential.

RACS supports the adoption of the Australian Institute of Health and Welfare (AIHW) national definitions for elective surgery urgency categories[5] that are based on the following principles:

- Simplified, time based urgency categories
- Surgeon determined categorisation
- A listing of the usual urgency categories for higher volume procedures (developed by surgical speciality groups)
- Comparative information disseminated about urgency categorisation
- 'Treat in turn' as a principle for elective surgery management, within the urgency categories
- Clarified approaches for patients who are not ready for surgery, because of clinical or personal reasons.

There is a need to improve efficiency and develop improved planning and scheduling systems in hospitals to meet the Australian National Elective Surgery Target (NEST).[6] RACS recognises that consistent collection of data and reporting of outcomes is vital to achieve ongoing improvement and refinement to the elective surgery urgency categorisation system. RACS also recognises that measurement of timing should commence from the time of referral rather than the first specialist surgical encounter.

Access to surgical assessment and intervention is controlled by the allocation of funding made available by governments who are responsible for the provision of health care in the public sector. RACS urges governments to continue to invest in surgical care and elective surgery as a matter of priority, in view of the increasing demands of the community and the increasing number of patients who seek treatment in the public system.

Single funding model

RACS is concerned about the 2.2% reduction in Commonwealth funding for the public hospital system from 2011–12 to 2012–13,[7] and further funding cuts from 2013 onwards, which have required the states and territories to make a greater contribution to hospital funding.[8] Any moves to further reduce Commonwealth funding for hospitals will result in increased surgery waiting times and a reduction in specialist outpatient services.

RACS supports a sustainable funding model approach, preferably with a single funder of public hospital services, with no scope for cost-shifting between governments. The current situation is untenable and counter-productive and there needs to be a better way to ensure the certainty of funding, transparency and accountability which patients and taxpayers require.

A single funder model would also allow governments to integrate primary care, community care and hospital care, leading to better health outcomes and reduced cost to the taxpayer. While we

acknowledge that a single funder model is a longer term objective, we would support any sensible reform that indicates that this model is the Government's ultimate goal.

THE IMPACT OF ADDITIONAL COSTS ON ACCESS TO AFFORDABLE HEALTHCARE AND THE SUSTAINABILITY OF MEDICARE

Medicare reimbursement rates

The Medicare Benefits Schedule is long overdue for reform, and RACS welcomes the Commonwealth Government's review announced in April 2015.

The existing freeze on Medicare rebates until 2018 means that in the meantime, patients are being subjected to higher out of pocket expenses as the cost of providing healthcare increases. Research shows that the effects of co-payments on preventative behaviour are greatest among those who can least afford the additional costs.[9]

It is the RACS position that at a minimum, Medicare reimbursement rates must keep pace with the Wage Price Index. WPI is the major measure of inflationary pressure on wages and salaries and has previously been used to index MBS items. While the Medicare rebate indexation remains at zero, the Wage Price Index (WPI) is at 2.3 per cent, and the cost of hospital and medical costs has increased by 6.5 per cent.[10]

THE IMPACT OF REDUCED COMMONWEALTH FUNDING FOR HEALTH PROMOTION, PREVENTION AND EARLY INTERVENTION

Concerns about cuts to preventative health agencies

Chronic diseases are Australia's leading cause of illness, death and disability, and have been described by AIHW as the nation's biggest health challenge.[11] They are caused largely by lifestyle factors such as physical activity, diet, smoking, alcohol and other drug abuse. Chronic diseases including heart disease, stroke and heart failure, chronic kidney disease, lung disease and type-2 diabetes, are together responsible for 90 per cent of all deaths in Australia.

Analysis of the 2004-05 National Health Survey showed that just over seven million people have at least one chronic condition, and the proportions having a condition increase with age, as do the proportions of people reporting more than one chronic condition.[12]

A government concerned about future productivity and extending the working life of Australians (which will benefit the income tax collected by Government in the future) should be investing more in preventing chronic disease, not less.[13] It is tempting to reduce funding for preventative health measures in the face of the more immediate and growing demands of acute services, but this will cost more in the long term. Apart from Budget cuts that have significantly reduced funding dedicated to preventative health, the Commonwealth Government has dismantled key advisory groups including the Australian National Preventive Health Agency, and the Australian Government's Preventative Health Taskforce. RACS supports adequate funding for preventative health measures that will reduce the impact of chronic disease on the health system into the future.

The burden of obesity

Dietary risks and high BMI are the two leading risk factors in Australia's burden of disease. In 2012, more than three in five Australian adults (63%) were overweight or obese (70% of men and 56% of women).[14] One in every six days spent in Australian hospitals is related to overweight and obese patients above the age of 45.[15]

The estimated annual cost of obesity in Australia (which has doubled since 2005) is $58.2 billion.[16] The financial costs account for $8.283 billion ($3.6 billion productivity costs; $2 billion health system costs; and $1.9 billion carer costs), while the net cost of lost wellbeing is a further $49.9 billion. Again,

preventative efforts to address this epidemic have been reduced, with annual funding of around $700,000 for the Collaboration of Community-based Obesity Prevention Sites ending on June 30.[17]

RACS believes a combination of preventative measures and an increase in the availability of treatment options for the already obese is the most effective way to address this issue.

In 2009 the Australian Government's Preventative Health Taskforce released a technical report on obesity, calling for urgent action.[18] RACS supports the Australian Government's role and the measures outlined in this report, including the development of a national plan to coordinate efforts to reduce obesity. We also recommend equity of access to weight loss surgery by publicly funding bariatric surgery for patients that meet appropriate clinical guidelines.

National solutions to reduce alcohol-related harm

The 2014 national Alcohol Policy Scorecard rated the Commonwealth Government as the lowest performing of all jurisdictions in terms of efforts to develop and implement evidence-based alcohol policy. Its score has dropped 20 percentage points since 2013, mainly due to the absence of a whole-of-government strategic plan to address alcohol-related harm.[19]

Funding has ceased for organisations that provided expert advice on ways to reduce the harmful impacts of alcohol, such as the Alcohol and Other Drugs Council of Australia, the Drug and Alcohol Prevention and Treatment Advisory Committee, and the National Indigenous Drug and Alcohol Committee.

Since 2010 there has been little action on:

- the development of a national alcohol strategy;
- alcohol taxation;
- regulation of alcohol marketing; or
- labelling of alcohol products.

RACS recommends that the Commonwealth consider the following key policy areas to reduce alcohol-related harm.

Taxation

The Henry Review of Australia's taxation system described Australia's present alcohol tax system as 'incoherent', and recommended a new approach based on a volumetric or alcohol content-based tax. The Australian Government's Preventative Health Taskforce also called for taxes on alcohol to be overhauled.

International scientific evidence consistently shows that rates of alcohol consumption and resultant harm are influenced by price.[20] Alcohol taxation is one of the most effective policy interventions to reduce the level of alcohol consumption and related problems, including mortality rates, crime and traffic accidents. Even small increases in the price of alcohol can have a significant impact on consumption and harm.[21] However, despite its reported effectiveness, taxation as a strategy to reduce alcohol-related harm has been under-utilised in Australia.[22]

The total cost to society of alcohol-related problems in 2010 was estimated at $14.352b, with an additional cost of $6.807b from alcohol's negative impacts on others. The same year, the Australian Government received an estimated $7.075b in total alcohol tax revenue.[23]

Data collection

Government agencies monitor and report incidents of alcohol-related harm and some of the costs associated with alcohol abuse, however, agencies do not monitor or report the total costs to the

community through alcohol related trauma and law enforcement, meaning we do not have a complete picture of the harm caused by alcohol in terms of its costs and effects on society.

Despite the evidence supporting the effectiveness of Screening and Brief Intervention (SBI) programs very few patients are asked about their alcohol use in the past year. A structured SBI program is inexpensive, takes little time to implement (5-10 minutes), and can be undertaken by a wide range of health and welfare professionals.

RACS supports further investigation into how a suitable SBI program could be implemented in Australia and New Zealand, in particular the mandatory collection of data on whether alcohol use is a factor in emergency department presentations, either by the patient or another individual. Since data is essential for good public policy, RACS also supports the mandatory collection of alcohol sales data.[24]

Reduce exposure

Australian studies have shown that exposure to alcohol advertisements among Australian adolescents is strongly associated with increased drinking patterns.[25] The National Health and Medical Research Council recommends that parents of adolescents delay the age of drinking initiation as long as possible to protect the health and wellbeing of young Australians.[26]

Given current high levels of drinking among Australian youth, RACS supports efforts to reduce young people's exposure to alcohol advertising through policy reforms aimed at reducing the proliferation of alcohol advertising. In particular, RACS encourages the Government to reduce children and young people's exposure to alcohol advertising on free-to-air commercial television by:

1. Allowing alcohol advertisements to be broadcast only during late evening viewing times.
2. Removing the provision that allows alcohol advertisements to be broadcast during televised sporting events on weekends and public holidays.
3. Removing exclusions under the definition of 'Commercial for alcoholic drinks' that may allow alcohol promotions during hours when children and young people will be watching.

Tobacco recommendations

Tobacco smoking is one of the leading preventable causes of premature disease and death in Australia. Smokers also have a higher chance than non-smokers of experiencing adverse perioperative events.

Australia is a member of the World Health Organisation (WHO) Framework Convention on Tobacco Control. This convention requires signatories to implement measures to reduce tobacco consumption. The Australian Government has taken significant steps to meet its obligations under the Convention by initiating a range of measures aimed at reducing the consumption of cigarettes. Australia was the first country in the world to introduce plain packaging laws in December 2012, and there is now conclusive evidence to show that this has reduced people's desire to smoke.[27]

RACS encourages the Commonwealth Government to continue working closely with all state and territory governments to reduce people's exposure to smoking through the numerous strategies outlined in the National Tobacco Strategy 2012-18. In particular, RACS supports a ban on smoking in all outdoor venues.

THE INTERACTION BETWEEN ELEMENTS OF THE HEALTH SYSTEM, INCLUDING BETWEEN AGED CARE AND HEALTH CARE

End of life care

Over the past 50 years, the development of modern medicine has seen Australia's average life expectancy increase dramatically.[28] Despite this, vitality and well-being are not always guaranteed, and many individuals experience impaired function, diminished mental capacity, and intense pain and discomfort towards the end of their lives. In such cases, it is important that patients are provided with

the means to make informed choices regarding their treatment, and where necessary, plan for the end of their lives.

Surgeons, like intensivists and other proceduralists, are often in situations where intervention and a period of increased medical support are required to improve a patient's status. In some cases, surgical intervention will be appropriate for critically ill and high risk patients. In other cases, surgical intervention may be futile or of low value to the patient.

A decision not to proceed with a surgical intervention can be difficult for both the surgeon and the patient or their family. This difficulty can be compounded where there are disagreements about the benefits of an intervention, or where there are cultural considerations contributing to misunderstanding. It is important that patients (and where necessary their families), are provided with sufficient information for their particular circumstances so that they may make informed choices about whether to proceed with a surgical intervention.

Advanced care planning provides a means of ascertaining a patient's wishes in situations where they are otherwise unable to give informed consent. This allows patients to express their expectations about future medical treatment should certain conditions arise. This can be a complex area, as not all eventualities can be predicted or discussed with a patient prior to surgery. Furthermore, surgical intervention can increase risk to patient function.

RACS strongly supports the development of advanced care planning and directives prior to surgery but notes that these are limited tools for ascertaining a patient's wishes in the setting of unexpected but potentially salvageable deterioration in the immediate postoperative period. The role of the surgeon regularly intersects with ICU and palliative care physicians. Surgeons therefore have a responsibility to ensure that patients are provided with appropriate, timely and high quality palliation. RACS strongly supports the rights of terminally ill patients to receive palliative medicine. RACS also recognises that palliative care for the purposes of pain relief will occasionally hasten the death of a patient. However, in line with existing legislation, RACS does not recognise any circumstances where palliative care should be used for the primary purpose of bringing about or accelerating the death of a patient.

IMPROVEMENTS IN THE PROVISION OF HEALTH SERVICES, INCLUDING INDIGENOUS HEALTH AND RURAL HEALTH

Recommendations to improve Aboriginal and Torres Strait Islander health outcomes

RACS is committed to addressing the health discrepancies of the Aboriginal, Torres Strait Islander and Māori populations of Australia and New Zealand.

In a country with one of the best healthcare systems in the world, it is unacceptable that Aboriginal and Torres Strait Islander people continue to experience poorer outcomes than non-Indigenous Australians.

The short policy cycles of Government and changing agendas make it difficult to execute the long-term planning required to deliver sustained improvements in Indigenous health. RACS believes in improving health outcomes independent of Government policy. RACS has turned its focus inward, with clear objectives to attract more Aboriginal and Torres Strait Islander people into its workforce as staff members and as surgeons, and to raise awareness about culturally appropriate healthcare. Government support for and assistance with incentives, grants, scholarships and good will projects will allow RACS to achieve these two objectives.

Better incentives within Continuing Professional Development will encourage more trainees and surgeons to explore Aboriginal health care. Funding cuts to the Rural Health and Continuing Education (RHCE) Program are concerning to organisations like RACS which endeavour to encourage Fellows and Trainees into rural, remote and particularly ATSI health. Funding cuts tend to have the opposite effect.

Practical barriers to accessing health care include geographical distance, perceptions of health, language barriers, financial constraints and availability of screening and follow-up services. RACS wishes to help encourage better coordination of care and facilitate communication between healthcare services. In many regional and remote communities, services to address diabetes, heart disease, kidney failure and ear disease are duplicated due to a lack of communication between healthcare providers.

RACS acknowledges that as a professional body of surgical specialists it also needs to encourage its members to provide services that are culturally acceptable and accepting of Indigenous people and their needs. This may require novel approaches to improve access to surgical services. The RACS Aboriginal and Torres Strait Islander Health Action Plan 2014-2016 commits the College to becoming an organisation that is more culturally competent, and RACS encourages governments to facilitate and guide cultural awareness training so it can be included in Continuing Professional Development accreditation.

Ear disease and associated hearing loss are significant health problems for Indigenous children, and can lead to delayed speech and educational development, low self-esteem, unemployment and a range of other health, social and economic problems.[29] RACS strongly recommends including ear disease as an objective in the Council of Australian Governments National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

Recommendations to improve the provision of rural health

People living in rural areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities. People living in very remote areas are 1.5 times more likely to be hospitalised than people living in metropolitan areas.[30]

For this reason, it is important that patients receive treatment as close to home as possible. Certain conditions, for example pancreatic cancer, may make this impractical, but it is feasible to provide high levels of general surgical care across all sub-specialties in regional centres.

Ongoing funding to improve infrastructure in regional centres will allow patients from remote centres to be treated closer to home and minimise displacement. Improved operating capacity must be matched with appropriate numbers of both medical and nursing/allied health staff.

THE BETTER INTEGRATION AND COORDINATION OF MEDICARE SERVICES, INCLUDING ACCESS TO GENERAL PRACTICE, SPECIALIST MEDICAL PRACTITIONERS, PHARMACEUTICALS, OPTOMETRY, DIAGNOSTIC, DENTAL AND ALLIED HEALTH SERVICES

Generalism

Specialisation within surgery facilitates the concentration and acquisition of knowledge and experience. It contributes to the setting of standards, research and advances in care. However, specialisation also has some disadvantages. It can lead to fragmentation of knowledge and patient care. Given that specialisation requires a critical size of population and institution it has implications for access to care, and especially access to emergency care for patients who live far from the relevant institution. This in turn can be a major problem for governments and hospital managers as they seek to provide a full range of accessible surgical services to all of their population within finite budgets.

RACS has adopted ‘Six principles of Generalism within Surgery’. These principles are relevant to practice within the nine specialty areas in which RACS recognises, trains and examines. They apply also to the relationship and cooperation between established specialties, sub-specialists, and specialists practicing across a number of recognised specialties.

The six principles of generalism within surgery are:

1. Rationale for sustainable health systems

The configuration of surgical services to all regions should be designed to provide safe, cost effective and equitable delivery of high quality surgical services to the whole population of Australia and New Zealand. This requires a mix of surgeons who specialise in a narrow range of conditions and surgeons who cover a broad scope or extended scope of practice working in cooperative relationships with each other.

In Australia, Surgeons working across a wide scope or extended scope of practice are particularly necessary and effective in providing for emergency surgery, services to regional areas, military and humanitarian work. They are also increasingly desirable for the oversight and management of many patients with multiple and complex conditions. Without these skills, the surgical services in many areas would become non-viable.

2. Appropriate training

Surgeons working across an extended scope of practice need initial broad training in multiple specialty areas to reflect the clinical needs. Historically surgical trainees were exposed to a broad experience in surgery in general before entering a specialist training program. Surgeons who intend to work in rural areas or other environments where an extended scope of surgery is desirable therefore need personalised, targeted and appropriate training in other specialty areas.

3. Context

To deliver a safe and high quality service to patients, surgeons working across a wide scope of practice and their institutions should establish cooperative, easily accessible and mutually supportive relationships with more specialised colleagues and specialised institutions.

Similarly, specialist and subspecialist surgeons must recognise their regional responsibilities and develop similar relationships with broad scope surgeons so that together they can ensure high quality care, irrespective of the patient's location. It is vitally important for the health of the population that extended and broad scope of practice surgeons and institutions are not in, or perceived to be in, competition with narrow scope surgeons and institutions.

4. Continuing professional development and audit

Continuous two-way, audit, education, learning and development should occur within and as an essential part of these mutually supportive relationships. Both the broad scope surgeon and the supporting specialist have an obligation to regularly review the audit data and use it to refine the service to improve the quality of care.

5. Location specific scope of practice

The scope of practice of all surgeons will be best determined by an assessment of local need and defined in the context of the wider regional service networks. The appropriate scope of practice will be location-specific and depend on the training and skill set of the extended or broad scope surgeon, available local facilities, linked services and existing or planned supportive specialist relationships.

There is no one size fits all in the provision of high quality surgical services to a whole population. Different contexts and different specialty services will need different solutions. Local needs, local skill sets and local support facilities will be an important factor in configuring the safe level of services that can be offered at a particular location.

While an 'area of need' surgeon may not always be a Fellow of the RACS, where possible it is preferable to fill such positions with FRACS holders or require a practicing surgeon to work towards obtaining the qualification.

6. Supportive legal and credentialing frameworks

RACS (in dialogue with Fellows, specialty and sub-specialty societies and jurisdictions) needs to foster a medico-legal and credentialing framework that facilitates extended and broad scope of practice surgery while protecting patients, institutions and jurisdictions. Medico-legal risk should be minimized in services in which there is good collaboration between the broad and narrow surgeons and where there is shared clinical responsibility.

In their role as expert witnesses to courts and membership of credentialing committees, surgeons are integral and important parties in establishing legal frameworks and local working environments for the practice of surgery. Broad and extended scope surgeons are particularly vulnerable to adverse rulings in legal matters if the context of practice is not taken into account.

For more information, please read our position paper on this issue.

HEALTH WORKFORCE PLANNING

Specialist medical training

The Commonwealth Minister for Health's funding commitment to extend the Specialist Training Program throughout the 2015-16 financial year was welcomed by RACS, however ongoing funding certainty is required to ensure new and established training posts can continue to be available for training. A sustainable funding model is required to ensure the time of trainers is protected, and that they receive appropriate remuneration.

An effective surgical service requires appropriate clinical loads, active clinical teaching, continuing professional development, and robust audit and peer review. Such a culture of excellence can only be sustained if these specific needs are acknowledged and addressed. Significant financial, infrastructural and cultural support from governments and health authorities is required to train and maintain the surgical workforce of the future.

There has been a substantial increase in the number of medical graduates entering the workforce and commensurate pressure on postgraduate training opportunities such as internships in hospitals and places in specialist medical colleges. There is also an increased need for surgeons in particular specialties and geographic locations.

While RACS puts no cap on the number of trainees it accepts, this is necessarily limited to the number of available surgical training posts in RACS teaching hospitals. This cap has not risen to meet the growing number of medical graduates who would like to pursue a career in surgery.

Training posts require an adequate level of clinical activity, with a good case-mix spread within the designated specialty, and committed supervisors and trainers. In times of workforce shortage there is significant pressure on all aspects of the health system to meet short term service demand, often at the expense of the quality of training and assessment. This undermines the quality of training and puts at risk patient safety and health outcomes.

Simulation is now an established and effective means of developing skills acquisition, including non-technical skills, but uptake has been limited to basic technical skill acquisition. With appropriate investment, government could facilitate the availability and diversity of simulation across the breadth of competencies required of surgical training. This investment would provide valuable training in a safe environment for both the trainee and patient, and contribute to improved patient outcomes.

Rural workforce planning

Retaining clinicians and succession planning is a significant issue in rural areas. RACS supports the establishment of rural training hubs, similar to the model that has been set up in Geelong Victoria, to attract and retain specialists in regional areas. Tasmania, NSW and Queensland are actively considering the Geelong model, which provides training locally so that people are more likely to be attracted to and stay in these areas. Medical students and junior medical officers are trained rurally, so there is no reason why registrars should not also be trained rurally. This would also help address the

geographic distribution issues found in particular specialties by spreading out the over concentration of specialists in urban areas.

RACS also encourages the Government to consider ways to ensure state and territory jurisdictions cooperate to deliver the best model of care for patients, particularly those in border towns. For example patients from Lismore Hospital in NSW are referred to Newcastle rather than the Gold Coast in Queensland, meaning they have to travel 7 hours instead of 1.5 hours. Appropriate geographic hubs would also allow clinicians to seek advice and share skills with colleagues in the same region.

Training hours

Surgical trainees usually have a formalised working schedule set out by hospitals in relation to overtime shifts and daily working hours. The number of rostered working hours will depend on whether the work occurs mainly during the day or at night. Trainees are also required to fulfil the minimum training requirements of the RACS Surgical Education and Training program, and hospitals must recognise this requirement and facilitate completion of the training program. Flexible training hours (at least 50% FTE) are available while recognising the complexities involved in meeting the needs of the surgical training program as well as the needs of the employing institution/surgical unit.

With a standard 38 hour work week in many hospitals, significant penalty rates are applied to hours worked above this. Hospitals are cutting back on the rostered hours of trainees due to cost cutting measures, which then affects the experience the trainee is able to gain to meet the requirements of the surgical education program.

RACS and its specialty training boards can only approve training positions in centres that maintain high standards of care, adequate clinical exposure for training, and support for trainees and trainers within the context of a structured program of education over a period of time. This includes all the tasks undertaken by physician trainees such as diagnosis, treatment and outpatient assessment, as well as operative and proceduralist training. RACS believes a 55-65 hour work week is appropriate for trainees to gain the knowledge and experience required by the training program, and this is supported by recommendations from US[31] and European[32] health systems.

Restricting surgical trainees to clinical practice of 38 hours per week may mean:

- Less exposure to operating lists which are the cornerstone of surgical training
- Reduced continuity of care, which may lead to more complications, longer hospital stays, more investigations and higher costs
- Lower quality training, in particular less generalist training and a reliance on sub-specialty fellowships as “de-facto extensions” for complete training.

RACS recognises that by endorsing a 65 hour working week, fatigue minimisation practices and safe rostering will need to be employed. [33]

RECOMMENDATIONS

In conclusion, RACS encourages the Commonwealth Government to give consideration to the following recommendations as a result of this inquiry.

1. Continue to invest in surgical care and elective surgery as a matter of priority, in particular by:
    a. Encouraging State and Territory health departments to address both the elective and outpatient lists cohesively and transparently.
    b. Providing guidance on ways to improve efficiency and develop improved planning and scheduling systems in hospitals to meet the Australian National Elective Surgery Target.
    c. Promoting use of the Australian Institute of Health and Welfare (AIHW) national definitions for elective surgery urgency categories, with clear criteria for assessing urgency for an outpatient assessment, and clear guidelines for categorisation.
    d. Providing adequate funding and support to the surgical profession to collect data for research purposes on surgical procedures and outcomes.
2. Implement a sustainable funding model approach, preferably with a single funder of public hospital services, with no scope for cost-shifting between governments.
3. Lift the freeze on Medicare reimbursement rates to allow reimbursements to keep pace with the Wage Price Index.
4. Increase the Commonwealth Government's commitment to preventative health measures by:
    a. Developing national plans to address obesity and alcohol-related harm.
    b. Publicly funding bariatric surgery to allow equity of access to weight loss surgery for patients that meet appropriate clinical guidelines.
    c. Implementing a volumetric tax on alcohol.
    d. Improving data collection to gain a better overall understanding of alcohol-related harms.
    e. Reducing young people's exposure to alcohol and associated promotions.
    f. Continuing to work closely with all State and Territory governments to reduce people's exposure to smoking through the National Tobacco Strategy 2012-18.
5. Support the development of advanced care planning programs and directives to assist with the healthcare of the older generation.
6. Better incentives to encourage more trainees and surgeons to explore Aboriginal health care.
7. Maintain funding for the Rural Health and Continuing Education (RHCE) Program.
8. Improve access to healthcare and facilitate communication between healthcare services in rural and remote areas.
9. Provide ongoing funding to improve infrastructure in regional centres and ensure that this is matched with appropriate numbers of both medical and nursing/allied health staff, and rural training hubs.
10. Consider ways to ensure State and Territory jurisdictions cooperate to deliver the best model of care for patients, particularly those in border towns.
11. Include ear disease as an objective in the Council of Australian Governments National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.
12. Support RACS 'Six principles of Generalism within Surgery'.
13. Provide ongoing funding certainty for the Specialist Training Program.
14. Recognise that restricting surgical trainees to clinical practice of 38 hours per week is not desirable, and that a 55-65 hour work week is appropriate for trainees, where fatigue minimisation practices and safe rostering are employed.

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