ADF Submission

to the

Senate Community Affairs Committee

into the

Health Workforce Australia Bill 2009

June 2009

Australians should not be subject to the blights of the British National Health System

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Health Workforce Australia Bill 2009
Executive Summary

1. The Australian Doctors' Fund (ADF) maintains that the Health Workforce Australia Bill 2009 will for the first time allow for the direct intervention of an unelected bureaucracy into Australian healthcare standards. **The HWA is an extension of the current rise of the unelected government of COAG and its desire to create systems and agencies that, whilst being answerable to multiple health ministers are virtually answerable to no-one.**

   Australia's future healthcare will therefore be in the hands of a **select group of state and federal health bureaucrats who having shown limited if any ability to run state public hospital systems will take unto themselves widespread powers to run the wider healthcare system** with minimal control by state or federal governments.

2. The ADF is concerned that the **Health Workforce Australia Agency is being rushed through the parliament** with limited consultation with Australian health professionals including the Australia medical profession. **The ADF therefore commends the Senate for calling this Inquiry** and providing an opportunity for the Australian medical profession to present its views to the Parliament.

3. The ADF believes that any proposed changes with the **capacity to impact adversely on Australian patients must be critically examined** and require substantial justification by their proposers based on clear evidence of their potential to enhance and maintain Australia's acknowledged high healthcare standards.

4. **The ADF does not believe that the HWA Agency will contribute significantly to any improvement in Australian healthcare and will duplicate existing functions. There is a strong possibility it will contribute to a deterioration in healthcare standards.**

5. The ADF believes that the **HWA Agency will repeat the considerable disasters of similar agencies in the UK**, which have seen a substantial disruption, and dislocation of the UK NHS workforce with claims of inadequate training for all doctors and especially surgeons, higher mortality and considerable political backlash.

6. The ADF believes that the substantial budget given to the **HWA will see the growth of more healthcare bureaucracy at the expense of directing funds into clinical training**. Furthermore these funds will be applied to training experiments which have already lowered healthcare standards in the UK. Given the international

models that exist to compare to HWA's proposals, ADF believes that there needs to be convincing evidence for the HWA proposal to be justified. **Such evidence needs to show not only cost benefit, but more importantly clinical quality and safety benefit**. **The ADF can find no such evidence.**

7. The ADF draws the attention of legislators to the considerable and expensive ongoing failures of those who claim expertise in manpower and **workforce planning** which has been described by the Productivity Commission **as "fraught with danger"**[1] and by the Federal Department of Health as **"a new art".**[2]

8. The ADF believes that Australia would be **better served to channel clinical training funds through existing training pathways** and the Federal Department of Health where public servants remain accountable to the Parliament via the Senate Estimates Committee.

9. The ADF requests that in the interest of public safety the **Senate demand answers to the claims of those expressing expertise in the efficacy of "competency training"** without the need for a comprehensive medical education in the whole body system i.e. those who come bearing gifts of quicker, shorter and cheaper training modalities should be treated with great caution (see Dr John Black's quote below)

10. The ADF draws the attention of Senators to the acknowledged high standards of the Australian medical profession including the Nobel Prize awards of many prominent and distinguished Australians in the discipline of medicine. **It should be noted that these achievements occurred in an environment of university-based medical education being the platform on which other specialists' competencies were built**. The ADF believes that this model will be threatened with the passage of the HWA.

11. Senators are urgently advised to **examine the track record of the proposed functions** of HWA and the changes that will be made to the Australia healthcare system **in light of the UK experience**, which is the template for the proposals now before parliament.

    The results are graphically described by Dr John Black, President of the Royal College of Surgeons, England who on 31 March 2009 wrote:

    One frustration of the present fiasco *is that although we all know that training has been compromised, with frighteningly thin logbooks due to surgeons in training not getting to theatre and outpatient clinics****, trainees are being signed off as having achieved their competencies and allowed to proceed****. Competence-based training, much beloved of Modernising Medical Careers and the Postgraduate Medical Education and Training Board, is of course fundamental and essential but it was pointed out by John Tooke in his seminal report that it* ***does not demonstrate excellence****, which we all seek. In the pursuit of competence we have* ***forgotten the role of experience****.* ***Our patients have not, of course****, and the one attribute they value above all in their surgeon is experience.*

[1] Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005, p.10
[2] The Australian Medical Workforce, Department of Health & Aged Care, August 2001, p.3

'If it ain't broke, don't fix it' *is a sensible way to conduct business, forgotten in the* ***modernisation mania of the last decade****, where everything had to be changed on principle. We now realise that* ***a lot of babies were thrown out with the bathwater****.* ***In surgery we had a good system****, where to become a member of the College you had to complete a two to three-year period of training in prescribed and inspected posts. The College would not recognise these posts unless they provided validated experience. Certain essential courses were compulsory. Specialist training could not start until basic surgical training was completed. The* ***exit exam for the FRCS has also been divorced from training****. Should it not be taken only in the final year, with robust logbook experience being essential before being allowed to attempt it?* ***Has the time come to put the clock back?***

When – and I mean when – the hours problem is sorted, the ***profession of surgeon will have an enormous responsibility*** *to use the deal, whatever form it takes****, to restore the standard of surgical training so that the system turns out doctors who are not just trained but adequately experienced for independent consultant practice in a reasonable time.***[3]

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9 June 2009

[3] President's Newsletter, The Royal College of Surgeons, England, Bulletin, March 2009, 91:154-155

Health Workforce Australia Bill 2009

1. The establishment of Health Workforce Australia (HWA) is an agreed outcome of the November 2008 Council of Australian Governments (COAG) meeting. Consistent with the November 2008 COAT Communiqué, the HWA is intended to have a number of functions including:
    a. Supporting health workforce research and planning;
    b. The provision of financial support for undergraduate clinical training;
    c. The provision of non-financial support for clinical training (eg matching students with clinical placements);
    d. Workforce redesign and reform; and
    e. The provision of advice to health ministers.

2. The ADF notes that the agency to be known as Health Workforce Australia (HWA) was not included in the COAG Intergovernmental Agreement (COAG IGA) and is not in the form recommended by the Productivity Commission Research Report which recommended the establishment of an advisory health workforce, education and training council.[4]

3. Furthermore, the ADF draws the Senate's attention to the qualifications that the Productivity Commission placed on its own recommendations including the establishment of a new council on health workforce, education and training, "*In this study, the Commission has taken as given these broad rationales for government intervention in relation to health services provision in general and the health workforce in particular. However, the actual nature and extent of intervention in particular situations is a matter for judgment – to be assessed against efficiency, effectiveness, quality and safety criteria."*[5]

4. In assessing the value of HWA, the ADF believes it is important to examine each function and the contribution the HWA is likely to make given its considerable use of taxpayer's funds.

5. What is the evidence that substantial investment in **health workforce research and planning** as proposed will deliver results? Given the diversity of models available for comparison in other developed economies, such evidence should be easily forthcoming; however the ADF can find no such evidence.

6. Until the 1980s the Australian medical workforce operated "*in a largely unregulated environment*"[6] and met the needs of the Australian population through 2 world wars and other major shocks to the Australian economy whilst delivering one of the highest standards of medical treatment in the world with a much lower

[4] Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005,Recommendation 5.2, p.xxxvii
[5] Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005, p.6
[6] The Australian Medical Workforce, Department of Health & Aged Care, Occasional Papers, New Series No 12, August 2001, Workforce planning a new art, p.3

number of doctors per 100,000 population than today.[7]

7. The intervention by Australian governments in the name of "medical workforce planning" corresponded with the increasing demand for medical services generated through the introduction of Medicare which followed growths in health expenditure in 1960s and 1970s and the expansion of medical education facilities, "*From 1984 introduction of Medicare, medical services were substantially subsidised from the Commonwealth on a universal basis accounting for large and increasing expenditure outlays. Significantly, spending on primary medical care was observed to increase with the supply of practitioners independently of population need".*[8]

8. Hence government interventions into the Australian medical workforce based on the advice of experts in medical workforce planning have resulted in an undersupply of medical graduates (on the basis of supply induced demand) requiring a dramatic increase in medical student numbers which has caused a bulge in the training supply line now being corrected with the creation of a new bureaucracy devoted to the same methodology that caused the problem in the first place.

9. Devotees of the accuracy and efficacy of what the Federal Department of Health has called "a new art" of workforce planning often understate or ignore the results of previous interventions in the name of workforce planning which rather than smooth adjustments to enable a better alignment between supply and demand actually contribute to shortages and gaps by wrong guessing future demand/supply requirements.

10. Despite a host of recommendations as to health workforce reform, the Productivity Commission wisely put a substantial disclaimer on medical workforce planning, "*Of course, attempting to predict the future is fraught with danger. While broad trends can be identified, the ways in which these trends will interact and play out are often unclear,"*[9] and "*Identifying 'shortages' in workforce supply is not straightforward, especially given the difficulty of establishing underlying health care demand and an appropriate level of workforce response, and the extensive involvement of governments in delivering or otherwise influencing the level of resources provided to meet that demand."*[10].

11. Given the failure of health workforce planning experiments the ADF contends that rather than invest in health workforce planning bureaucracy the only viable strategy in uncertain future health demand environments is to abandon picking winners and ensure sufficient funding for a steady and digestible increase in the Australian medical workforce. Such a strategy does not require over-arching bureaucracy.

[7] The Australian Medical Workforce, Department of Health & Aged Care, Occasional Papers, New Series No 12, August 2001, p.13. Doctors per 100,000 population, 1929(86 per 100K population), 1943(85), 1953(116), 1964(111), 1972(139), 1986(228), 1993(238),1998(244) [est by ADF 2009(285)]
[8] ibid, p.3
[9] Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005, p.10
[10] ibid, p.11

12. In regard to future 'doom scenarios' in health workforce numbers, experienced parliamentarians are well aware that these scenarios have been a constant theme of the Australian political landscape. In 1987 the Health Issues Centre declared 1,400 nursing vacancies in Victorian public hospitals; 1,100 in NSW; and 3,500 nationally[11]. The ADF believes that doom scenarios should be treated with appropriate scepticism. This is not to say there will not be pressures due to foreseen and unforeseen factors on the health workforce in general and the medical profession in particular. However the creation of bureaucracies and training paths based on guesswork will inevitably result in frustrated career paths and wasted resources.

13. Furthermore legislators are also aware that governments both state and federal have introduced restrictions on the productivity of doctors and other health professionals as to the number of subsidised services that can be delivered. This is most evident in the state public hospital system which rations elective surgery in line with budget constraints. The Australian Society of Orthopaedic Surgeons has estimated that its members could increase their capacity to operate on public patients by between 30-40% within the current workforce arrangements should elective surgery budget restrictions be lifted.[12]

14. The ADF does not believe that the HWA will contribute to improving the rural/urban imbalance in the Australian medical workforce. The ADF asserts that the HWA will make this imbalance worse by moving decision-making further away from the local level where flexibility and practicality are needed. The ADF notes that substantial initiatives have been undertaken to address this issue including Federal Government support for ACRRM (The Australia College of Rural and Remote Medicine). ACRRM represents an outstanding contribution by Australian rural doctors who support with teaching, training and clinical placement the development of a larger Australian rural medical workforce. Much more work needs to be done to enhance ACRRM's ability to develop rural medical practitioners and to ensure the complexities of practising rural medicine are reflected in government policy.

15. Furthermore universities such as Notre Dame, Sydney are conducting undergraduate training modules in rural settings and other medical schools have introduced rural training experiences especially via their rural clinical schools. Hence the solution to this problem is dedicated hard work and appropriate funding, not greater bureaucracies such as HWA placing greater demands on an over-worked rural medical workforce. The need for greater investment in rural health infrastructure to build on these training initiatives cannot be overstated. Appropriately funded rural training opportunities will not only solve the problem of placing junior doctors into meaningful fulfilling training but will also go a long way to addressing the workforce shortage. Enthusiastic rural medical registrars are welcome and much needed in the Australian rural division of the Australian medical profession.

[11] Medicare, A Double Edged Sword, Health Issues Centre, February 1987, p.24

[12] Dr James Sullivan, Australian Society of Orthopaedic Surgeons media release, We have the doctors but not the operating theatre time, 23.2.05

16. In the UK, government blind acceptance of the illusionary promises of agencies devoted to workforce planning has resulted in a public backlash with frustrated politicians having to deal with the results,

    "MPs partly blame the demanding targets set by government for the chaotic hiring and firing of staff that has been seen in the NHS during the past 12 months. This, together with a huge injection of cash for the NHS, led to what they call a "boom and bust" approach to workforce planning".[13]

17. The ADF contends that in exercising **the function of the provision of financial support for clinical training** and with a budget of $1.2 billion the HWA will succumb to the temptation to cream off clinical training dollars in the establishment of a large administrative bureaucracy as per the UK.

18. The ADF is concerned that in exercising a function entitled, **the provision of <u>non-</u> financial support for clinical training (eg matching students with clinical placements)** the HWA will be tempted to experiment with mashing clinical placements through a variety of health undergraduates and hence dissipate critical learning experiences for medical students. This has the potential to devalue the medical degree course which is of considerable concern particularly given the substantial investment of Australian taxpayers, medical students and international medical students in attaining a quality medical degree.

19. The ADF contends that in exercising the function of **workforce redesign and reform** the HWA will engage in failed experiments in top-down imposed workforce role substitution. The Australian medical profession, (contrary to unsubstantiated accusations), have not exhibited a resistance to functional change provided that the change evolves from a workplace setting and does not escalate risk for those who bear final accountability for patient safety. Furthermore, those who have over-confidence in the ability of workforce redesign to generate substantial savings and efficiencies need to subject their claims to critical examination as to where success has been achieved and what savings have been made.

    Legislators would be acutely aware of the difficulties that will arise should Australians be subject to imposed care i.e. restrictions on who they may approach for certain conditions particularly in primary care.

20. The ADF believes that **the provision of advice to health ministers** is a function of Federal and State Health Departments.

21. The ADF's concerns are to do with the use of the HWA as a vehicle for health workforce planning and shaping. As such the ADF maintains that the HWA is a clone of the UK NHS health agencies who have intervened in medical workforce planning with disastrous results.

22. The ADF maintains that the HWA has every possibility of causing greater disruption to clinical training of the health professions than any possible enhanced

[13] Zosia Kmietowicz, BMJ 2007;334:653 (31 March), doi:10.1136bmj.39167.372002.DB

improvement. It is clear from the functions of the agency that it will not only seek to fund clinical training at the undergraduate level but will also adopt the functions of a health workforce change agency with the potential to use funding as a weapon to shape Australia's health workforce in the image of the bureaucrats who will administer the scheme.

23. Furthermore, all legislators should be concerned that there is no definition of what clinical training is and the "types of courses" that will be considered eligible for funding by the HWA. Apparently this will be left to Ministerial discretion (i.e. bureaucratic directive)

24. The ADF would also recommend that legislators demand answers from those who chant the new mantra of "competency-based training" as a panacea for alleged workforce shortages. The Australian medical profession has always insisted that, in the interest of maintaining the highest possible standards, all competency training be based on a foundation of broader medical education and that in the undertaking of their skills, doctors set clear lines of accountability. Proposals to mash medical education and other health workforce training requirements run the danger of creating blurred lines of accountability and fuzzy understandings of what should and should and should not be done in clinical settings. The operating theatre is no place for post-modernist experimentation.

Conclusion

The Australian Doctors' Fund does not believe that there is a substantive case for the HWA and is concerned that as a statutory authority it would not be subject to full parliamentary scrutiny. It is change for change sake. Its promises are seductive to those who do not wish to critically examine the likely impact of the processes it would introduce.

The ADF is unaware of any cost benefit analysis or any patient safety impact statement that has been produced to justify its creation.

The ADF believes there is substantive evidence that the HWA is seeking to reproduce in Australia several of the functions of agencies in the UK NHS and in particular a centralised and bureaucratic redesign of the Australia health workforce along ideological lines.

The ADF does not believe it is an exaggeration to state that the HWA is part of a process of the pre nationalisation of the Australian medical profession and as such will be detrimental to the standards of care that Australians have enjoyed and expect.

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