ANZCA
FPM

6 February 2025

Counsel Assisting the Special Commission of Inquiry into Healthcare Funding
Via email contact.hfi@specialcommission.nsw.gov.au

Dear Counsel,

Special Commission of Inquiry into Healthcare Funding - closing submissions outlining findings and recommendations

Thank you for providing ANZCA the opportunity to provide feedback on the Special Commission's draft findings and recommendations (dated 20 December 2024).

The college has reviewed the report, with this letter containing the college's feedback. We have focused on the Executive Summary content on pages 6-18. We can confirm that this feedback is suitable for publication by the Inquiry, and we look forward to the release of the final report later this year.

Feedback

1. The college is pleased that the report confirms **a shortfall in anaesthesia specialists** compared with available positions (pages 201 and 203) which is generally accepted in the NSW health community.
2. We understand the recommendations are largely at a system level and recognise this is necessary to cover the wide scope of the Inquiry, however we were hopeful that the report would contain **greater tangible or concrete recommendations which can (and must) be directly implemented, without any need for interpretation or the ability to backtrack or not implement**. We feel currently the report findings and recommendations contain statements which may be open to interpretation of need or importance and doesn't convey where items are essential for action by NSW Government. ANZCA urges for the inclusion of greater tangible findings, wording or examples which can (and must) be actioned by NSW Government.
3. It would be valuable to have the recommendations or introduction begin with an overarching comment about the need for NSW Health (and Australian governments in general) to adequately fund access to first world medical care for all people in NSW. With subsequent points touching on **what should change to see universal health care achieved in NSW**.

   Every Australian is entitled to safe, high quality, evidence-based medical care, provided at the time of need, for those in need, irrespective of means. This currently doesn't occur in NSW as we lack the funds to employ, train and retain staff, compounded by access based on geography rather than clinical need.
4. Further to point #2, on the top of page 11 (point 16d) we are unsure why the word *should* is included as 'should' (extract below). This may read as it is not essential for addressing. Further description may be required to warrant the use of apostrophes in this context.

   > *Identification of which of those gaps the public health system 'should' fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community, clinicians and all other providers of health care within the relevant place;*
5. Point 25c on the bottom of page 13 (extract below) identifies the need for **specialist medical training networks for all medical specialties**.

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It is unclear whether this would be across all medical specialities or a separate network for each medical speciality. If the former, this may be seen as difficult to agree and see actionable change across all medical specialities as medical specialities operates differently. For example, some Australian medical colleges set the number of training places, however ANZCA does not set the number of training places. ANZCA accredits training hospitals however the number of trainees, and therefore number of new Australian anaesthetists, is controlled by state and territory health departments and their affiliated hospitals.

Regardless, this is assumed to be the inclusion of an extra layer of governance / administration, together with NSW Health, LHDs and medical colleges, which may not always result in effective and timely results and change. Noting that the objective of ensuring sufficient training numbers is essential.

> *the establishment and delivery of specialist medical training networks for all medical specialties, prioritising those with projected shortfalls in trainee numbers compared with service and workforce demands, in collaboration with the relevant medical colleges and local organisations, with the objective of matching the number and locations of placements and training positions with areas of future service and workforce need and focusing upon maximising opportunities for training and recruitment in rural and regional locations.*

6. **Health workforce funding and the need for award reform** was a key item that was discussed and raised by many stakeholders during the hearings and submissions. Unfortunately, only point 26 refers to legislated award reform, however this in the context of the *process* of legislated award reform (presumably for future incorporation) rather than addressing the current award insufficiencies and the need for award reform to attract and retain the clinical workforce and stopping the current haemorrhage of staff from public to private and from NSW to interstate.

7. **Activity based funding** is used for delivery of the bulk of healthcare in NSW, however it is not a useful model for starting a new service, rapid expansion of an existing service, provision of emergency/trauma services or delivery of any kind of niche service. It makes the system slow and unresponsive to the needs of communities. Consideration of other flexible funding types should be strengthened in the report – funding is currently only referred to in point 17 and is at the heart of almost all components of NSW healthcare operations and issues.

   An example of this is the national bowel screening programme, which has created an **abrupt and significant increase in demand for endoscopy services**. TV adverts encourage the public to ‘Get 2 it’ but if there is a positive test, public waitlists for endoscopy (even with direct access) are in excess of 18 months. Another example of unmet need. For example, the Central Coast LHD has over 5000 patients on the waiting list. Without specific funding to increase service provision commensurate with demand (which ABF can’t achieve), it’s impossible to meet demand.

8. Medicare rebates need to be better thought through for activity-based funding to be helpful where it’s appropriately applied. In chronic pain, there are many item numbers for procedures, making it a highly lucrative private practice. However, the outcome evidence shows no benefit of an interventional approach over a non-interventional approach. This is a far less costly care but with outcomes equal to the more expensive (and lucrative, in terms of rebate-able items) interventional model. If the **Medicare rebates better remunerated the non-interventional approach (or reduced remuneration to the interventional approach)**, it would lessen the lure of specialist pain medicine physicians to the private sector and enable the public sector to recruit the occasional specialist. By recognising the significant input of non-medical clinicians in this space, again would encourage allied health/nursing/psychology staff to work in chronic pain and encourage LHDs to grow and fill this massive unmet need.

It is recognised that Medicare is the responsibility of the Commonwealth Government, however state and territory health departments should advocate/advise federal government of the appropriateness of rebates based on their operational environment, so Medicare can be kept updated and relevant. Chronic pain is a relevant example of where the many rebates for interventional work is advantaging the private sector and disadvantaging the public sector.

We're happy to discuss any of these issues further should you have any associated queries.

Yours sincerely,

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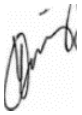

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