Australian Competition & Consumer Commission

Determination

Application for Authorisation

lodged by

The Royal Australasian College of Surgeons

in respect of

The selection, training and examining of surgeons in specialities in which the College conducts training

The College's role in accrediting hospitals for basic surgical training and hospital posts for advanced surgical training

and

The College's role in assessing overseas-trained doctors

Date: 30 June 2003

Authorisation No: A90765

Register: C2000/1775

Bhojani
Jones
Martin
McNeill
Willett

Executive Summary

On 28 November 2000, the Royal Australasian College of Surgeons (the College) lodged application for authorisation[1] A90765 with the Australian Competition and Consumer Commission (the Commission). The College lodged a submission in support of its application for authorisation with the Commission on 30 March 2001, at which time the Commission's assessment process commenced. This submission is summarised in Chapter 6 of this determination.

The College

The College is a private professional association established in 1927 and incorporated in 1930 in Melbourne, Victoria. Approximately ninety per cent of Australian surgeons are College Fellows.

Origins of the College's application

The College's application followed a two-year investigation by the Commission into allegations that the College's processes restrict entry to advanced medical training in breach of the Act. The Commission's investigation focused on the College's role in deciding how many trainees received advanced training in orthopaedic surgery and how it assesses overseas-trained surgeons.

In September 2000, the Commission informed the College that it considered that this conduct may breach the Act. In response, the College informed the Commission on 9 October 2000, that it intended to apply for authorisation for its training and assessment processes. On 19 October 2000, the Commission stated that it would suspend its investigation while the application was being genuinely pursued.

The College's application

The College has sought authorisation for its primary functions which are as follows:

- selecting, training and examining trainees in basic surgical training and in each of the nine surgical sub-specialities in which advanced surgical training is offered;
- accrediting hospitals as being suitable for basic surgical training if they meet standards set by the College;
- accrediting individual hospital posts as being suitable for advanced surgical training if they meet standards set by the College; and

[1] The ACCC has the function, through the authorisation process, of adjudicating on certain anti-competitive practices that would otherwise breach the *Trade Practices Act 1974*. Authorisation provides immunity from court action, and is granted where the ACCC is satisfied that the practice delivers offsetting public benefits. Applications for authorisation are considered on a case by case basis and involve broad public consultation with interested parties. The onus is on the applicant to demonstrate that there is a public benefit arising from the conduct and that the public benefit outweighs any public detriment.

- assessing the qualifications, training and experience of overseas-trained practitioners who wish to work as surgeons in Australia to determine whether they are equivalent to Australian-trained surgeons.[2]

Surgical training and examination

Medical graduates wishing to become surgeons must complete two years of basic surgical training and between four and six years of advanced surgical training depending on the specialty. The College administers these training programs and College Fellows do the actual teaching.

Broadly, surgical trainees are apprenticed to College Fellows. Over the course of basic and advanced surgical training, the scale and complexity of the surgical tasks trainees perform is increased so that, by the time they have completed training, they are ready to undertake all the operations expected of a surgeon in a particular specialty without supervision.

In addition, trainees must pass a 'Part 1' exam at the end of basic surgical training and a 'Part 2' exam at the end of advanced surgical training. The College sets, administers and marks these exams.

Selection of trainees

Prospective trainees must apply to the College to obtain a position in basic surgical training and apply again (2-4 years later) for a place in advanced surgical training. The College determines the selection process (assessment based on curriculum vitae, interview performance and referees' reports), sets the selection criteria and ranks applicants against these criteria. It also determines the 'cut-off' standard below which applicants are not eligible to enter training.

Accrediting hospitals and hospital posts

Basic surgical training may only take place in hospital posts in *hospitals* accredited by the College. Advanced surgical training may only take place in *hospital posts* accredited by the College. The College sets the criteria for accrediting hospitals for basic training and hospital posts for advanced training. It also appoints teams of College Fellows to ascertain whether hospitals/hospital posts meet the relevant criteria and makes the final decision about whether to grant accreditation.

Assessing overseas-trained surgeons

Doctors, including overseas-trained surgeons, may only practise in Australia if they are registered by one of the state or territory medical boards. Commonwealth, state and territory governments have established a system under which the College assesses whether overseas-trained surgeons wishing to practise in Australia are equivalent to Australian-trained surgeons. The College appoints assessment teams of College Fellows to assess individual applicants. The College then forwards a recommendation to the relevant medical board, which is almost invariably accepted. The recommendation will usually be one of the following:

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[2] The College conducts advanced surgical training, and assesses overseas-trained surgeons, in the following specialities: cardiothoracic surgery (heart and chest), general surgery, neurosurgery (nervous system, including brain), orthopaedic surgery (skeletal system), paediatric surgery, plastic and reconstructive surgery, otolaryngology (ear, nose and throat), vascular surgery (blood vessels) and urology (urological tract).

- that the applicant be required to complete basic and/or advanced surgical training in Australia before being registered; or

- that the applicant be required to complete a period of supervised assessment in a hospital position before being registered.

Commission assessment process

The Commission conducted an extensive public consultation process to assist its consideration of the College's application. In particular, the Commission actively sought the views of state and territory government health ministers and agencies, which are the largest employers of surgeons in Australia.

The Commission initially invited public submissions immediately after receiving the College's application in March 2001. Submissions were ultimately received from nearly all health ministers, largely in the second half of 2002. These submissions are summarised in Chapter 11 of the Commissions draft determination and outlined, where relevant in Chapter 13 of this determination. Broadly, governments supported authorisation being granted provided concerns held by nearly all of them regarding transparency, accountability, fairness and consistency of the College's processes were addressed.

Other submissions were received from, among others, state and territory medical registration boards, specialist medical colleges, industry associations, consumer groups, private health insurance funds and university medical faculties.

In total, the Commission received over 100 substantive submissions in relation to the College's application.

Draft determination

On 6 February 2003, the Commission issued a draft determination proposing to grant authorisation, subject to conditions.[3]

In its draft determination, the Commission considered that the College's training and assessment processes generated public benefits, particularly in the form of maintaining high surgical standards and because the College provides certain services on a pro bono basis. However, the Commission also concluded that the public detriment from the College's processes is likely to be significant, in particular because: surgeons involved in the College's training and assessment processes posses a conflict of interest; College fellows have the means to restrict entry into surgical practice, and; interested parties, and in particular state and territory governments, had raised sufficient concerns about the College to justify a finding of significant public detriment.

The Commission was not satisfied that the public benefit generated by the Colleges application outweighed the public detriment. However, it considered that, by granting authorisation subject to a number of conditions, aimed at reducing the public detriment generated by the College's training and assessment processes, a net public benefit would be generated.

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[3] Copies of the Commission's draft determination are available from the Commission's website: www.accc.gov.au.

The conditions proposed by the Commission were primarily aimed at providing a greater role for governments in standard setting and implementation of the College's training and assessment processes, and improving the transparency of College processes. These conditions are summarised in Chapter 12 of the Commission's draft determination and are similar to the conditions ultimately imposed in this final determination.

Public consultation in response to the draft determination

The Commission engaged in a further extensive public consultation process after releasing its draft determination. In particular, the views of state and territory health ministers and agencies were again actively sought.

Ultimately, health ministers provided a joint submission in response to the Commission's draft determination through the Australian Health Ministers Conference (AHMC). The AHMC's submission was broadly supportive of the draft determination. Its concerns largely related to the detail of some conditions proposed in the draft determination.

In its response to the draft, the College expressed strong concerns about the public detriment findings in the draft determination. In particular, it submitted that any references to its processes being anti-competitive should be deleted. The College reiterated its view that its processes do not breach the Trade Practices Act. Having said this, it indicated that it could comply with most of the proposed conditions, subject to minor fine tuning in some cases. It expressed more significant concerns about a small number of proposed conditions.

The Australian Consumers' Association, while supporting the proposed reforms, did not consider they went far enough. The Australian Medical Association broadly supported the College's response to the draft determination.

The views of the AHMC, the College and other interested parties on particular issues are reproduced in Chapter 13 of this determination.

Commission evaluation

Public benefit (see paragraph 13.223)

The Commission is satisfied that the College's training and assessment processes generate a significant public benefit by assisting to ensure that surgical training is of a high quality. High surgical training standards are likely to generate significant benefits for the community by excluding unqualified surgeons from the market, thereby contributing to:

- a lower rate of adverse outcomes from surgery leading to longer and better lives for patients; and

- reduced time in and/or fewer visits to hospital, thereby reducing costs for the public hospital system, Medicare, private health insurers and ultimately consumers.

Clearly, a range of other factors will also contribute to achieving these outcomes. This fact is highlighted by the establishment by health ministers in January 2000 of the Australian Council for Safety and Quality in Health Care to lead national efforts to improve patient safety and the quality of health care in Australia.

The second major public benefit claimed by the College is that surgeons organise and provide training on a pro-bono basis. In particular, it claimed that surgeons provide pro-bono work

valued at more than $230 million per annum (not including $70 million in capital costs).

To the extent that surgical training is provided on a pro-bono basis, the Commission considers that this constitutes a clear public benefit.

Training provided by surgeons in hospital hours – that is, the surgical apprenticeship – comprises over 90 per cent of the value of surgeons' pro-bono work as claimed by the College. However, some state and territory governments have submitted that surgeons are paid for this training. Others agree with the College. The Commission is unable to form a view on this important issue given the conflicting submissions it has received.

However, as regards the remainder of the College's pro-bono claim (that is, training other than that provided by surgeons in hospital hours) the Commission is satisfied that surgeons provide most of these services on a pro-bono basis. The value of these services is in the order of $20-25 million per annum.

Public detriment (see paragraph 13.52)

The College possesses significant influence over the number of surgeons entering surgical practice. In particular, the number of trainee surgeons is limited by the number of advanced training posts in hospitals which meet College standards. Overseas-trained surgeons entering practice in Australia are, in practice, limited by the College's assessment as to whether they are equivalent to an Australian trained surgeon.

The College maintains that its training and assessment processes are based on the need to ensure that appropriate standards are maintained and raise no competition concerns. However, significant concerns have emerged during the course of the Commission's assessment of the College's application that its processes have been used to restrict the number of surgeons. These include:

- the Australian Orthopaedic Association, which administers orthopaedic surgical training on behalf of the College, ignoring a target for the number of orthopaedic surgical trainees determined by the Australian Medical Workforce Advisory Committee (AMWAC);[4]

- the College erecting 'invisible barriers' to overseas-trained surgeons wishing to enter practice in Australia – for example, by information booklets not being sent when requested, interviews not being held, or multiple interviews being held imposing considerable costs on applicants;

- the string of complaints received by the Commission since it began investigating the College from, for example, surgical trainees, candidates for surgical training and overseas trained surgeons, who nearly universally are unwilling to make their complaint public for fear that the College learning of their complaint would end their chances of, for example, winning a place in the College training program. This almost universal requirement for confidentiality suggests that a widespread perception exists within the medical community that the College does not necessarily administer its training and assessment processes in an appropriate manner.

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[4] The Australian Medical Workforce Advisory Committee was established by Commonwealth, state and territory governments to calculate the number of trainee medical specialists, including trainee surgeons, required to ensure that enough specialists exist to meet community needs.

The control of entry restrictions has far-reaching consequences for the Australian community. Such restrictions affect the availability, regional distribution, quality and price of surgeons' services. The Commission considers that the supply of such an important professional service as surgery is too important a community issue for the selection, training and assessment of surgeons to be left solely in the hands of the profession through the College and its Fellows.

In particular, surgeons undertaking selection, assessment and accreditation activities possess a conflict of interest. Requiring that surgical training standards, hospital training posts and overseas-trained surgeons meet high standards generates clear community benefits. However, standards that exceed what is required to ensure that surgeons are safe and competent inappropriately limit the size of the surgical profession, with significant negative impacts on the availability, distribution and affordability of surgery. More generally, the College's expertise is in surgical practice and techniques. It is therefore not well-placed to take into account broader community considerations such as access, distribution and affordability.

Significantly, the College's responses to the draft decision issued in February display a broader inability to accept that its processes impact on competition in the surgical profession.

In particular, the College disputes that it influences the number of surgeons entering surgical practice. However, this is self-evidently what entry standards do. The benefit to the public will outweigh the detriment if standards are set at an appropriate level – if not, the public will be disadvantaged by an unjustified reduction in the affordability and availability of surgery.

Consequently, while acknowledging that the College has worked co-operatively with health departments and the ACCC to refine the conditions proposed in the draft determination, the ACCC is concerned about the longer-term commitment of the College to ensuring that its processes do not inappropriately impact on competition. Unless the concerns about the College have subsided, the ACCC is likely to carefully consider whether granting a further authorisation is appropriate.

Shortage of surgeons

The need for reform is particularly important given that evidence of a surgeon shortage is now emerging. A report to the ACCC prepared by Professor Jeff Borland of the University of Melbourne and published in the ACCC's draft determination found likely shortages of surgeons in a majority of surgical sub-specialties including the two largest sub-specialties – general surgery and orthopaedic surgery. A copy of Professor Borland's report is at Attachment C to the determination.

In addition, a number of factors suggest that there could be a severe shortage of surgeons in the coming years. These include: the ageing Australian population; the ageing Australian surgical profession; increased demand for Australian surgeons overseas; the reluctance of younger surgeons to work the excessive hours many surgeons have traditionally worked; and the implementation of 'safe working hours' policies.

The ACCC welcomes the fact that the College has now recognised this shortage in its just-released Birrell Report. This report also claimed that the shortage of surgeons is exclusively the fault of government. The Commission disagrees for the reasons provided in this determination.

The reforms

The Commission has imposed a range of reforms to the College's processes. The reforms are intended to find an appropriate balance between the need for the College to remain substantially involved in the setting of surgical training and assessment standards given its technical expertise, while concerns about the College's processes are addressed.

Broadly, the Commission is proposing the College be required to:

- establish a review, through an independently chaired committee, of the criteria for accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training and implement such changes (if any) to the accreditation criteria as are recommended by the review (see Attachment D to this determination). This review will also examine whether the College should accredit hospitals or hospital posts for advanced surgical training and whether training in non-accredited posts can be retrospectively recognised (see paragraph 13.278);

- invite health ministers to nominate persons to participate in the assessment of hospitals (for basic surgical training) and hospital training posts (for advanced surgical training) (see paragraph 13.293);

- invite health ministers to nominate any hospitals for basic surgical training and/or hospital training posts for advanced surgical training for which they wish to seek accreditation (see paragraph 13.299);

- introduce more timely processes for assessing hospitals and hospital posts and advise health departments, area health services, applicants and the general public of the outcome of its decisions (see paragraph 13.304);

- establish an independently chaired committee to publicly review the test for assessing overseas-trained surgeons (see Attachment E to this determination). The College will be required to prepare public guidelines consistent with this review on how it applies the test (see paragraph 13.307);

- invite health ministers to nominate a panel of persons available to participate in the assessment of overseas-trained surgeons (see paragraph 13.317);

- introduce more timely processes for assessing overseas-trained surgeons; require written reasons to be provided to applicants about decisions; allow overseas-trained surgeons who have previously been assessed to re-apply under the new system; and publish annually details of the assessment process (see paragraph 13.322);

- to the extent that they are not already, ensure that the College's processes for selecting basic and advanced surgical trainees are consistent with the Brennan principles of trainee selection (see Attachment F to the determination) (see paragraph 13.334);

- invite health ministers to nominate person to selection panels for basic and advanced surgical training (see paragraph 13.334);

- publish annually a range of information about the College's selection, training and examination processes, including outcomes and require more information to be provided to unsuccessful applicants (see paragraph 13.353);

- consult health ministers before finalising the limit on the number and distribution of basic surgical training posts for a particular year (see paragraph 13.355);

- to the extent that it has not already, reach agreements with each specialty society involved in advanced surgical training as regards their accountability, obligations and responsibilities to the College. These societies are required to act in accordance with the College's direction (see paragraph 13.362);

- alter the composition of its Appeal Committee so that it is comprised as follows:

  - a majority of members (one of whom shall be the Chairman) nominated by the Australian Health Ministers Conference; and

  - a minority of College Fellows (see paragraph 13.368);

- amend its rules to improve procedural fairness, transparency and credibility of the appeals process, including requiring the issue of written reasons for decisions; and

- use its best efforts to establish appropriate memoranda of understanding with the Australian Health Ministers Conference or individual health ministers as appropriate to facilitate the practical implementation of the conditions of authorisation (see paragraph 13.394); and

- develop a consumer consultation policy (see paragraph 13.398).

In proposing these conditions of authorisation the Commission has considered the range of concerns raised by interested parties, and particularly state and territory governments and health ministers.

The reforms proposed are also designed to assist governments to address the specific shortage of surgeons in rural and regional areas. Trainee surgeons are an important part of the hospital workforce. The proposed reforms ensure that governments will, for the first time, be consulted on the standards that hospitals need to met before trainee surgeons can work in them. This will allow governments input into whether a wider range of hospitals, and particularly rural and region hospitals, could accommodate trainee surgeons without any fall in training standards. It will also allow distribution of new training posts to be in accordance with community priorities.

Alternative models – Hunter Area Health Service/University of Newcastle proposal

In its draft determination, the Commission emphasised the importance of recognising that high quality alternative systems for training and assessing surgeons could exist.

It noted, in particular, that Australian universities offered surgical training in the first half of the 20th century (see paragraph 4.5). In addition, universities train specialist dentists (in addition to the Royal Australasian College of Dental Surgeons).

The Commission welcomes the fact that key government and educational institutions are now turning their minds to the possibility of the establishment of new medical specialist training programs that may not involve the existing medical colleges.

At the least, the recognition that alternative training programs could exist is likely to increase pressure on the existing colleges to improve their performance. However, from a competition

perspective, the actual entry of one or more competitors (subject to obtaining AMC accreditation) into medical specialist training markets monopolised by the existing colleges would be likely to generate substantially greater benefits in the form of ongoing pressure to maintain and improve quality on all players in the market, as well as pressure to ensure that student fees are no more than they need to be.

The Commission is therefore particularly encouraged by the Hunter Area Health Service and the University of Newcastle proposal (which may go ahead with or without the College's involvement).

As well as potentially ending the existing monopoly, this proposal potentially signals a move away from medical specialists exclusively controlling the training of their future competitors towards a more balanced group of interests exercising control.

The Commission will be liaising closely with Hunter Health and the University of Newcastle as they seek to establish their new training program, as well as actively monitoring the situation generally.

The Commission will vigorously investigate all complaints that the development or ongoing operation of the new training program is being impeded by anti-competitive activity.

Wider reforms

As noted above the Commission has assessed the College's application for authorisation against the background of government workforce planning arrangements. In doing this, inadequacies in these workforce planning arrangements have become apparent. In particular:

- the ACCC became concerned about AMWAC's methodology. While the ACCC's concerns about some of the earlier reviews of surgical specialties remain, it welcomes the fact that AMWAC's methodology has improved and that the ACCC's concerns have been taken into account. It further welcomes the fact that AMWAC will soon be re-examining key surgical sub-specialties;

- the ACCC welcomes the submission by health ministers affirming that they have an obligation to implement AMWAC recommendations. Health ministers also submitted that each state and territory will now annually report on its implementation of AMWAC recommendations. However, the ACCC reiterates that it seems difficult for governments to meet AMWAC targets without some form of state or territory-wide co-ordination of the process (which could also identify funding requirements); and

- the ACCC became concerned about whether the test for determining whether overseas-trained medical specialists, including surgeons, should be able to practise in Australia – this is, that they be 'equivalent' to Australian-trained specialists – was too imprecise. This matter is now being reviewed as part of the review of how the College assesses overseas-trained surgeon.

These reforms, along with the reforms proposed by the Commission to the College's training and assessment processes, should be seen as a package aimed at ensuring that a sufficient number of surgeons are practicing to meet the needs of the Australian community for high-quality surgical care into the future.

Proposed period of authorisation

The Commission proposes to grant authorisation to the College's processes for:

- selecting basic and advanced surgical trainees;
- training basic and advanced surgical trainees; and
- examining basic and advanced surgical trainees

for six years, subject to the relevant conditions listed above.

This term will allow the Commission to re-assess these processes in the light of the assessment of the Specialist Education Accreditation Committee of the AMC in 2007 as to whether the College's accreditation (initially granted until 31 July 2008) should be extended for a maximum of four years.

The Commission proposes to grant authorisation to the College's processes for:

- assessing overseas-trained surgeons;
- accrediting hospitals for basic surgical training; and
- accrediting hospital posts for advanced surgical training

for four years.

These processes have attracted considerable criticism from interested parties. This warrants an earlier review by the Commission of whether the public benefit generated by these processes continues to outweigh any public detriment.

Interim authorisation

The College has had interim authorisation[5] for its processes since the Commission's consideration of its application commenced. The protection afforded by interim authorisation has been extended until the Commission final determination comes in to force.

[5] The ACCC may grant an interim authorisation while it considers an application for authorisation. Interim authorisation provides the same immunity from court action as provided by authorisation proper.

Abbreviations

AHMAC	Australian Health Ministers' Advisory Committee
AHMC	Australian Health Ministers' Conference
AHWOC	Australian Health Workforce Officials Committee
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
AON	Area of need
AST	Advanced Surgical Training
BAST	Board of Advanced Surgical Training
BBST	Board of Basic Surgical Training
BST	Basic Surgical Training
Commission	The Australian Competition and Consumer Commission
College	The Royal Australasian College of Surgeons
HIC	Health Insurance Commission
OSAC	Overseas Specialist Advisory Committee
SRAC	Specialist Recognition Advisory Committee
the Act	The *Trade Practices Act 1974*

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Appendixes

1. INTRODUCTION

1.1 The Australian Competition and Consumer Commission is the national agency responsible for administering the *Trade Practices Act 1974*. A key objective of the Act is to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.

1.2 The Act, recognises that competition may not always generate the most efficient outcome. It therefore allows the Commission to grant immunity from the Act for anti-competitive conduct in certain circumstances.

1.3 One way businesses may obtain immunity is to apply for what is known as an 'authorisation' from the Commission. Broadly, the Commission may 'authorise' businesses to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment.

1.4 The Commission conducts a comprehensive public consultation process before making a decision to grant or deny authorisation.

1.5 Upon receiving an application for authorisation, the Commission invites interested parties to lodge submissions outlining whether they support the application or not, and their reasons for this.

1.6 The Act requires that the Commission then issue a draft determination in writing proposing either to grant the application (in whole, in part or subject to conditions) or deny the application. In preparing a draft determination, the Commission will take into account any submissions received from interested parties.

1.7 Once a draft determination is released, the applicant or any interested party may request that the Commission hold a conference. A conference provides interested parties with the opportunity to put oral submissions to the Commission in response to a draft determination. The Commission will also invite interested parties to lodge written submissions on the draft.

1.8 The Commission then reconsiders the application taking into account the comments made at the conference (if one is requested) and any further submissions received and issues a written final determination.

1.9 This document is a final determination in relation to application for authorisation A90765 lodged with the Commission by the Royal Australasian College of Surgeons (the College).

Extension of the Trade Practices Act to the professions

1.10 When it was enacted in 1974, for constitutional reasons, the Act only applied to incorporated businesses. However, in April 1995, Commonwealth, state and territory governments agreed to extend the provisions of the Act prohibiting anti-competitive conduct to unincorporated businesses, including the professions.

1.11 Subsequently, each of the Australian state and territory Parliaments passed legislation extending the competition provisions of the Act to unincorporated businesses. This was done by mirroring the competition provisions of the Act in the Competition Code in each jurisdiction. Since that time, the competition provisions of the Act have been applied to all professionals, including health practitioners such as surgeons. Moreover, professional associations and professionals have been able to apply for authorisation, and thereby obtain immunity from these provisions.

The College's application

1.12 On 28 November 2000, the College lodged application A90765 with the Commission. The application was made under subsection 88(1) of the Act and the Competition Codes for each state and territory for authorisation to give effect to a contract, arrangement or understanding, a provision of which has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

1.13 A full submission in support of the application for authorisation was lodged by the College with the Commission on 30 March 2001.

1.14 The application seeks authorisation for the College's processes in:

- selecting, training and examining basic surgical trainees and advanced surgical trainees in each of the nine sub-specialities in which it conducts training;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

1.15 These processes are referred to in this determination as the College's **training and assessment processes**. The College seeks authorisation of its training and assessment processes for an indefinite period of time.

Entering surgical practice in Australia

1.16 Surgeons practising in Australia have either:

- completed the College's training program; or
- are overseas-trained practitioners whose qualifications and experience have been assessed as being equivalent to Australian-trained surgeons, or assessed as being competent to perform specific procedures (outlined within a position description) in areas where there is a shortage of doctors (that is, an area-of-need position).

1.17 An overview of entering surgical practise in Australia and the limits on entering the surgical profession in Australia is provided in Chapter 2 of this decision. Chapters 6, 7 and 8 examine the role of the College, the Australian Health Ministers' Conference (and the Australian Medical Workforce Advisory Committee) and of individual state and territory governments respectively.

Commission investigation preceding application for authorisation

1.18 Following the extension of the Act to the professions, the Commission began receiving complaints that the College's processes restrict entry to advanced surgical training in breach of the Act.

1.19 In 1998, the Commission commenced investigating the College's role in determining the number of trainees in orthopaedic surgery and how it assesses overseas-trained specialists. In September 2000, it informed the College that it considered that this conduct may breach the Act. On 9 October 2000, the College indicated that it would be applying for authorisation. On 19 October 2000, the Commission stated that it would suspend its investigation while the application was being genuinely pursued.

1.20 The College subsequently applied for authorisation of its processes as described above at paragraphs 1.12 – 1.14.

1.21 The College asserts that none of its training and assessment processes breach the Act. Nevertheless, the College submits that it has applied for authorisation to remove any uncertainty regarding this issue.[6]

Previous inquiries

1.22 In 1988, the Doherty Report concluded that the medical workforce should be monitored more closely than in the past, and recommended the establishment of an ongoing 'Medical Workforce Review Committee'.[7]

1.23 In recent years, a number of inquiries have examined aspects of the College's training program and/or its assessment of overseas-trained surgeons. These include:

- the Baume Inquiry, which examined a wide range of issues relating to the surgical workforce including workforce numbers, distribution of surgeons, surgical remuneration, waiting lists, hospital staffing and surgical training;[8]
- the 1998 Brennan Review of selection processes of medical colleges and the development of a 'best practice' framework for trainee selection;[9] and
- the Race to Qualify Report, which examined a wide range of issues in relation to the assessment and registration of permanent and temporary resident doctors trained overseas.[10]

1.24 Also, in February 2002, the Australian Medical Council (AMC) released its findings from its review of the specialist education and training programs of the College. The College was granted AMC accreditation for its training and education programs for six years, extendable to ten years, subject to certain requirements being met.

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[6] The Royal Australasian College of Surgeons, supporting submission to the application for authorisation, 30 March 2001, page 5.

[7] *Australian Medical Education and Workforce into the 21st Century – Report of the Committee of Inquiry into Medical Education and Workforce,* 1988.

[8] *A Cutting Edge: Australia's Surgical Workforce, Report of the Inquiry into and Supply of, and Requirements for, Medical Specialist Services for Australia*, 1994.

[9] *Trainee Selection in Australian Medical Colleges*, January 1998.

[10] *The Race to Qualify Report for the Review of Practices for the Employment of Medical Practitioners in the New South Wales Health System*, October 1998.

Draft determination

1.25 On 6 February 2003, the Commission released a draft determination proposing, subject to a number of conditions, to authorise the College's training and assessment processes.

1.26 The Commission considered that the College's training and assessment processes generated public benefits, particularly in the form of maintaining high surgical standards and because the College provides certain services on a pro bono basis. However, the Commission also concluded that the public detriment from the College's processes is likely to be significant, in particular because: surgeons involved in the College's training and assessment processes possess a conflict of interest; College fellows have the means to restrict entry into surgical practice; and interested parties, particularly state and territory governments, had raised sufficient concerns about the College to justify a finding of significant public detriment.

1.27 The Commission was not satisfied that the public benefit generated by the College's application outweighed the public detriment. However, it considered that, by granting authorisation subject to a number of conditions, aimed at reducing the public detriment generated by the College's training and assessment processes, a net public benefit would be generated.

1.28 The conditions proposed by the Commission were primarily aimed at providing a greater role for governments in standard setting and implementation of the College's training and assessment processes, and improving the transparency of the College's processes.

Interim Authorisation

1.29 On 30 March 2001, the College requested interim authorisation for its training and assessment processes. The College requested interim authorisation on the grounds that interim authorisation was necessary to protect it from any civil claims that may arise in respect of its training and assessment processes prior to the Commission determining the substantive application.

1.30 On 4 May 2001, the Commission granted interim authorisation for the College's training and assessment processes until the date of the Commission's issuing of a draft determination in relation to the application for authorisation, or 31 December 2001, whichever was the earlier.

1.31 On 1 November 2001, Commission amended the period of interim authorisation to be until the date the Commission issues a draft determination.

1.32 On 6 February 2003, the Commission extended the period of interim authorisation until a final determination is issued.

1.33 The Commission extends interim authorisation until the Commission's final determination comes into effect.[11]

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[11] In accordance with s.101 of the *Trade Practices Act* 1974 a person dissatisfied with the Commission's determination has the right to apply to the Australian Competition Tribunal for a review of the determination.

Chronology

1.34 The chronology of the Commission's consideration of application A90765 is summarised in Table 1.1 below.

1.35 The Commission has conducted an extensive consultation process in its consideration of the College's application. In particular, the Commission recognises the integral role that state and territory governments play in the training and assessment processes for surgeons. For example, it is the role of state and territory governments to provide funding for training places within public hospitals. In this regard, the Commission actively sought the view of state and territory government health ministers and agencies.

Table 1.1: Chronology

Date	Action
28 November 2000	Application for authorisation received from the Royal Australasian College of Surgeons (the College).
30 March 2001	Received substantive submission in support of the application for authorisation and related attachments from the College. At this time, the College applied for interim authorisation of its training procedures.
2 April 2001	Letters seeking comment on the application sent to interested parties. The closing date for submissions was 4 May 2001.
19 April 2001	The Commission denied interim authorisation based on limited information supplied by the College to support the request. However, the Commission indicated it would be willing to reconsider a further submission for interim authorisation and indicated the key issues required to be addressed.
23 April 2001	Request to reconsider interim authorisation received from the College.
26 April 2001	Commission requests additional information from the College in support of the request for interim authorisation.
30 April 2001	Additional information received from the College in support of interim authorisation.
4 May 2001	Based on the additional information, the Commission granted interim authorisation for the College's training and assessment processes.
11 May 2001	Commission seeks additional information from the College regarding its application.

17 May 2001	Additional information received from the College, including a copy of the College's accreditation submission to the Australian Medical Council (AMC) and accompanying folder of attachments.
17 August 2001	Commission letter seeking additional information from state and territory health departments.
27 August 2001	Submission received from Department of Health and Human Services Tasmania in relation to August issues letter.
30 August 2001	Meeting with Health Department of Western Australia in relation to August issues letter.
13 September 2001	Meeting with ACT Department of Health, Housing and Community Care in relation to August issues letter.
2 October 2001	Meeting with Queensland Health in relation to August issues letter.
17 October 2001	Letter from the College seeking an extension of interim authorisation until the application for authorisation is finalised.
1 November 2001	The Commission amended its original decision so that interim authorisation extends until the Commission issues its draft determination.
13 November 2001	Received submission from NSW Health.
16 November 2001	Letter from the College requesting that the Commission extend interim authorisation until a final determination is issued.
5 December 2001	The Commission maintained its decision of 1 November 2001 in respect to interim authorisation.
7 December 2001	Commission seeks further information from NSW Health.
14 December 2001	Letter to the Department of Human Services Victoria in relation to specific issues arising from the public consultation process.
14 December 2001	Letter to the College seeking further information on specific issues arising from the public consultation process.
18 January 2002	Received information from Department of Human Services Victoria in response to December issues letter.
20 March 2002	Received information from the College in response to December issues letter.
15 April 2002	Received further submission from Western Australian Department of Health.

9 May 2002	Submission received from the Hon Bob Kucera, Minister for Health Western Australia.
10 May 2002	Received additional submission from NSW Health.
19 July 2002	Commonwealth, state and territory health ministers requested a copy of the College's application and a further opportunity to comment on, or provide personal input into, the Commission's public consultation process.
24 July 2002	Received outstanding information from the College in response to December issues letter.
6 August 2002	Commission wrote to Commonwealth, state and territory health ministers, in response to request made by the Australian Health Minsters' Conference at its meeting on 19 July 2002 in Darwin.
11 September 2002	Received submission from the Hon Lea Stevens, South Australian Minister for Health.
25 September 2002	Received additional information from the Hon Bob Kucera, Western Australian Minister for Health.
25 September 2002	Received submission from the Hon Wendy Edmond, Queensland Minister for Health.
30 September 2002	Received submission from the Hon John Thwaites, Victorian Minister for Health.
10 October 2002	Received submission from Senator the Hon Kay Patterson, Commonwealth Minister for Health and Ageing indicating that the relevant issues had been addressed in the previous submission from the Commonwealth Department of Health and Ageing.
23 October 2002	Received submission from Jon Stanhope, ACT Minister for Health.
24 October 2002	Received letter from the Hon Craig Knowles, New South Wales Minister for Health indicating that the relevant issues had been addressed in the previous submissions from NSW Health.
6 February 2003	Draft determination proposing to grant conditional authorisation to the College's training and assessment processes. Interim authorisation extended until final determination issued.
13 March 2003	Received submission in response to the draft determination from the College.
18 March 2003	Pre-determination conference held in Melbourne.
29 May 2003	Submission received from Hunter Area Health Service.

6 June 2003	Received further submission on the draft determination and issues arising from the pre-determination conference from the College.
25 June 2003	Received joint submission on the draft determination from the Australian Health Ministers' Conference, comprising health ministers from the Commonwealth, states and territories and the Minister for Veterans Affairs.
30 June 2003	Final determination granting authorisation to the College's training and assessment processes, subject to conditions. Interim authorisation extended until the final determination comes into effect.

Overview of the determination

1.36 The determination consists of sixteen chapters. These are:

- Chapter 2 – an overview of the system for entering surgical practice in Australia;
- Chapter 3 – a statistical overview of the surgical workforce in Australia;
- Chapter 4 – the history of surgical training in Australia;
- Chapter 5 – the College;
- Chapter 6 – the College's training and assessment processes for which authorisation is sought;
- Chapter 7 – the role of the Australian Health Ministers' Conference and Australian Medical Workforce Advisory Committee in work force planning;
- Chapter 8 – the role of individual state and territory governments;
- Chapter 9 – greater detail in relation to the net public benefit test applied by the Commission in its consideration of the application for authorisation;
- Chapters 10, 11 and 12 – summary of the submissions received by the Commission on the application for authorisation from the College and various interested parties;
- Chapter 13 – the Commission's evaluation of the application;
- Chapter 14 – the Commission's summary of related issues;
- Chapter 15 – concluding remarks; and
- Chapter 16 – the Commission's determination.

2. ENTERING SURGICAL PRACTICE IN AUSTRALIA – AN OVERVIEW

Practising surgery in Australia

2.1 Surgeons in Australia may choose to practise in the public and/or private sector in one of nine sub-specialties.

Surgical sub-specialties[12]

2.2 *General surgery* is the core sub-specialty within the discipline of surgery and is the broadest of the surgical sub-specialities. A general surgeon is a surgical specialist engaged in the comprehensive care of surgical patients and in some situations the general surgeon may require knowledge of the whole field of surgery. While technically encompassing any type of surgery, it is largely limited in practice to operations not usually performed by other sub-specialties.

2.3 *Cardiothoracic surgery* is the medical specialty devoted to the surgical management of intrathoracic diseases and abnormalities. A cardiothoracic surgeon may perform surgical procedures relating to the heart, lung or great vessels.

2.4 *Neurosurgery* provides for the operative and non-operative management of disorders that affect the central, peripheral and autonomic nervous system, including the brain and spinal cord.

2.5 *Orthopaedic surgery* is surgery of the muscular skeletal system as a whole, including the treatment of bones which have not grown correctly or which have been damaged.

2.6 *Otolaryngology – head and neck surgery* deals with the diagnosis and treatment of diseases of the ear, nose and throat.

2.7 *Paediatric surgery* is the surgical treatment of children (usually up to the age of 16 years). Paediatric surgeons normally deal with non-cardiothoracic surgery, general paediatric surgery and paediatric urology.

2.8 *Urology* deals with the diagnosis and treatment of diseases of the kidneys, bladder, ureter and urinary tract.

2.9 *Vascular surgery* is concerned with procedures on all arteries except the coronary and intracranial arteries and included many aspects of venous disease.

2.10 *Plastic and reconstructive surgery* is surgery to reduce scarring or disfigurement that may occur as a result of accidents, birth defects or treatment for diseases. It is a wide ranging speciality involving manipulation, repair and reconstruction of the skin, soft tissue and bone.

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[12] The College's submission to the Commission, 3 June 2003, Attachment 2.

Public sector

2.11 Patients are entitled to be treated for free in public hospitals administered by state and territory governments.

2.12 Surgeons who work in the public hospitals are either:

- engaged as Visiting Medical Officers (VMOs), usually on a part-time basis; or
- employed as salaried medical officers, usually on a full-time basis.

2.13 These surgeons are paid by the entity that has engaged them, rather than by the patient.

Private sector

2.14 Surgeons who wish to work in the private sector must obtain two approvals.

2.15 First, the Commonwealth government funds the Medicare system, under which patients are entitled to receive rebates to assist in meeting the cost of doctors' services. Surgeons must be recognised by the Health Insurance Commission before their patients may receive Medicare rebates. This is discussed further at paragraphs 2.46–2.57.

2.16 Second, surgeons who work in the private sector must be approved by a private hospital before being able to perform procedures there. The Commission understands that private hospitals determine whether to approve a new surgeon acting on the advice of 'credentialing' committees usually constituted by surgeons already approved to work at the hospital.

Entering the surgical profession in Australia – locally trained surgeons

2.17 Persons (other than overseas-trained practitioners) wishing to enter the College's surgical training program must first complete a Bachelor of Medicine and Bachelor of Surgery (MBBS) or equivalent at an Australian or New Zealand university and an intern year.[13] They then have to apply to the College for a place in its basic surgical training program. Trainees move through a minimum of two years of basic surgical training (in general surgical practice and principles) after which they apply for a position in one of the advanced surgical training programs in each surgical sub-specialty. These programs are between four and six years in length and generally culminate in a final year examination.[14] Trainees who complete the College's surgical training program are granted a College Fellowship. Greater detail about the College's training processes is provided in Chapter 6 of this determination.

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[13]This will generally enable them to be registered as a medical practitioner – see paragraphs 2.33-2.35. South Australia and Queensland also have specialist medical registers. The award of a College Fellowship upon completion of the College's training program would entitle surgeons to specialist registration (see paragraphs 2.36-2.38).

[14]In general surgery the examination is normally undertaken in year 3 of the 5 or 6 year program.

Limits on entering the surgical profession in Australia – locally trained surgeons

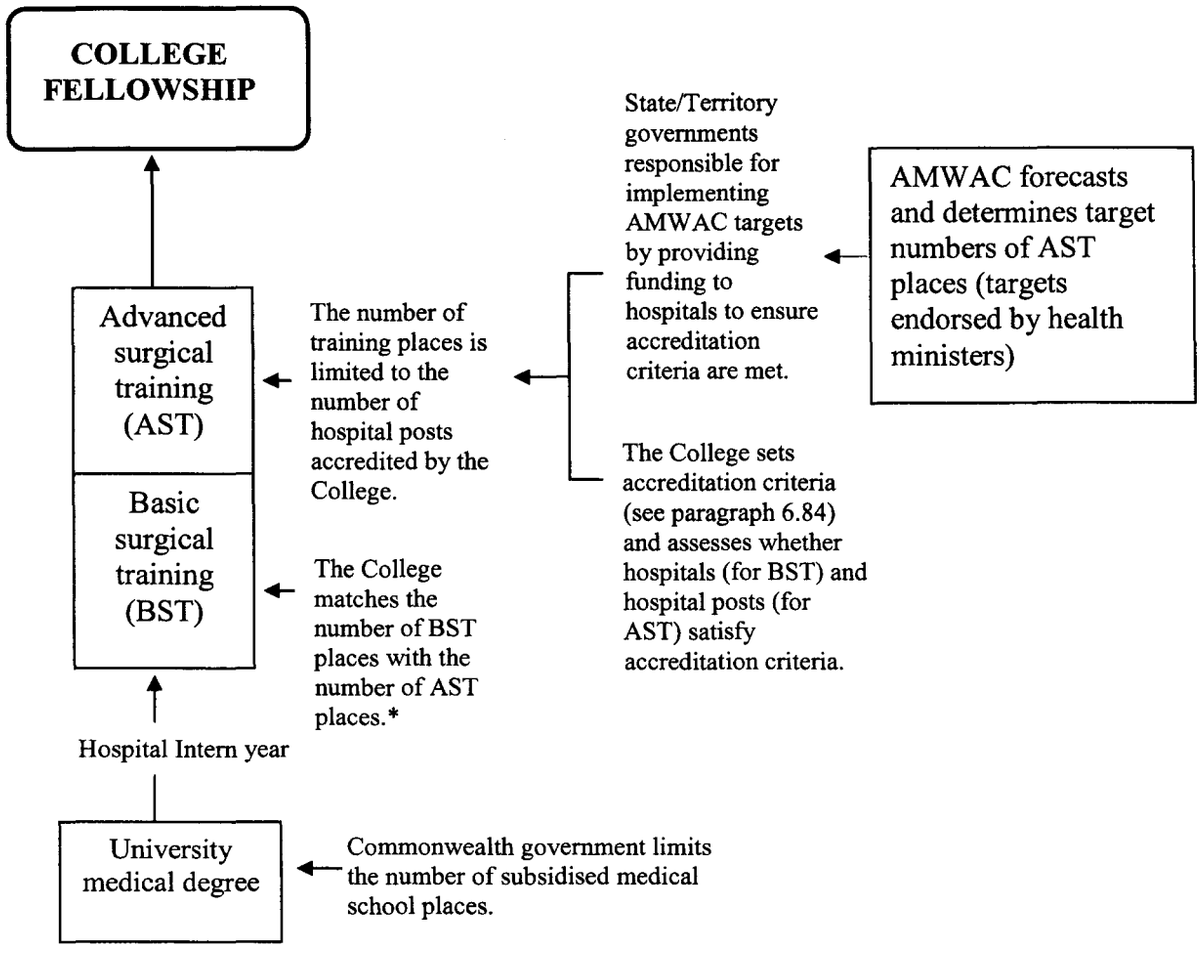
2.18 There are a number of influences on the number of surgeons trained in Australia. Figure 2.1 below depicts the limits on the number of locally trained surgeons entering the surgical profession in Australia. These limits include:

- the Commonwealth government limits the number of subsidised medical school places;
- target numbers of advanced surgical training places determined by the Australian Medical Workforce Advisory Committee (AMWAC) and endorsed by the Australian Health Ministers' Conference (AHMC);
- the number of advanced surgical training posts accredited by the College (and the number of hospitals accredited by the College to undertake basic surgical training); and
- the amount of funding provided by state and territory governments to ensure that the College's accreditation criteria for hospitals (for basic surgical training) and hospital posts (for advanced surgical training) are met.

2.19 The number of surgeons trained is also dependent on the number of applicants attracted to each of the surgical sub-specialties. The Commission understands for example that the number of qualified applicants to the neurosurgery training program of the College has decreased in recent years. AMWAC reports that the main reasons for this may be related to the nature of neurosurgery work (that is, demands of a neurosurgery practice and hours of work), the cost of medical indemnity insurance and working conditions.[15]

[15] Australian Medical Workforce Advisory Committee, *The Neurosurgery Workforce in Australia Supply and Requirements 1999-2010,* August 2000.

Figure 2.1: Limits on the number of surgeons trained in Australia[16]



* The number of basic surgical training places is also limited to the availability of places in the basic training skills courses, which is dependent on the number of trainers from the College.

[16]Figure 2.1 compiled by the Australian Competition and Consumer Commission.

Medical school places

2.20 The Commonwealth Department of Health and Ageing is responsible for monitoring university medical school intakes and the distribution of medical school places. The Commonwealth also limits the number of subsidised medical school places. In 1999, 1334 students commenced an undergraduate degree in medicine, compared to 860 students in 1995 and 1392 students in 1991.[17]

2.21 The Commonwealth government recently announced that an additional 234 Australian medical school places will be made available in 2004, taking the total to 1704 students commencing an undergraduate degree in medicine in 2004. This represents a 16 per cent increase in the total number of places across Australia.[18]

2.22 Specifically, universities in NSW and the ACT will receive funding for a combined total of 94 additional student places, Victoria 10 extra places, Queensland universities 50 extra places, Western Australia 50 additional places, South Australia and the NT combined 14 additional places and 21 extra places will be funded in Tasmania. Students in these places will be bonded for six years to work in areas of workforce shortage upon completion of medical training.[19]

Australian Medical Workforce Advisory Committee (AMWAC)

2.23 In 1995 the Australian Health Ministers' Conference established the Australian Medical Workforce Advisory Commission (AMWAC) to provide advice on the number of medical specialist training places required to ensure that future workforce numbers are sufficient to meet patient demand.

2.24 The number of advanced surgical training places is therefore influenced by the workforce planning recommendations of AMWAC. Ultimately, health ministers endorse the target number of advanced surgical training posts in each state and territory acting on the advice of AMWAC. The role of AMWAC in medical workforce planning in Australia is discussed in greater detail in Chapter 7 below.

Implementation of AMWAC recommendations by states and territories

2.25 Implementation of health ministers' decisions regarding the number of surgical trainees requires action by state and territory health departments and the College. Where an increase in the number of trainees is required in a particular surgical sub-speciality, these new positions must meet the College's standards for training posts. To achieve this increase, state and territory governments would need to ensure that sufficient funding is provided to public hospitals to ensure that the required number of training posts meets the College's accreditation standards. The role of individual health departments is discussed in greater detail in Chapter 8.

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[17] Australian Institute Health and Welfare, *Medical Labour Force 1998,* Table 39, p47.
[18] Senator the Hon Kay Patterson, Minister for Health and Ageing, Media Release, 5 June 2003.
[19] Ibid

College accreditation of hospital posts for advanced surgical training and hospitals for basic surgical training

2.26 The College determines the criteria which must be met by hospital posts to be accredited for advanced surgical training and hospitals to be accredited for basic surgical training. Teams appointed by the College assess whether hospitals and hospital posts, as the case may be, meet its accreditation criteria. As previously noted, the College's training and assessment processes are detailed in Chapter 6.

Entering the surgical profession in Australia – overseas-trained surgeons

2.27 Overseas-trained surgeons wanting to practise surgery in Australia must first satisfy Australian immigration requirements. They must also obtain medical registration from the relevant state or territory medical registration board. Overseas-trained surgeons wanting to enter private practice must obtain a Medicare provider number.

Limits on overseas-trained surgeons entering the surgical profession in Australia

2.28 Limits on overseas-trained surgeons entering the surgical practice in Australia include:

- Australian immigration requirements;
- the need to be registered by state and territory medical registration boards, which entails the overseas-trained surgeon being assessed by the College; and
- the Commonwealth government's ten year moratorium from 1 January 1997 on granting Medicare provider numbers to overseas-trained practitioners.

Areas-of-need

2.29 'Areas-of-need' are areas in each state and territory – usually rural and regional areas – where the state or territory government has determined there is a shortage of doctors.[20]

2.30 To encourage overseas-trained doctors to work in areas-of-need, various exemptions from immigration, medical registration and Medicare restrictions are provided to overseas-trained doctors who opt to work in these areas. These exemptions are noted in the relevant sections below.

Immigration requirements

2.31 Overseas-trained surgeons (who are not already Australian citizens or permanent residents) must first satisfy Australia's immigration requirements before being able to practise in Australia.

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[20]See, for example, *Medical Practice Act 1992* (NSW), section 7D; *Medical Practitioners Registration Act 2001* (Qld), section 135; *Medical Act 1894* (WA), section 11AF(1)(D).

2.32 To control growth in the number of doctors in Australia, medical practitioners are excluded from the major elements of Australia's skilled migration stream; that is, the Skilled-Independent and Skilled Australian-sponsored visa categories.[21]

2.33 Having said this, a number of ways exist by which overseas-trained doctors can obtain visas that would allow them to reside permanently in Australia. For example:

- they may be sponsored by their Australian spouse under the family migration stream of Australia's migration program.[22] It appears that, in 1996 at least, most medically trained migrants fell into this category;[23]

- they may apply under the Employer Nomination Scheme (ENS) or the Regional Sponsored Migration Scheme (RSMS). These schemes are designed to enable Australian employers to recruit highly skilled workers from overseas where they are unable to fill vacancies locally. For example, a public hospital in an area-of-need could seek to sponsor an overseas-trained surgeon under the ENS or RSMS. However, before applying under these schemes, an overseas-trained surgeon would need to apply to the Australian Medical Council for an assessment of his or her experience and qualifications. This assessment would be undertaken by the College on behalf of the Australian Medical Council (see Chapter 6);[24] and

- some overseas-trained surgeons may qualify under Australia's refugee and humanitarian program.

2.34 Doctors may also obtain temporary resident visas to fill hospital positions in areas-of-need. Visas are generally granted for as long as the doctor's conditional registration by the state or territory medical board extends (which will be for the length of the contract of employment).[25]

College assessment of overseas-trained surgeons for purposes of registration by state and territory medical boards

2.35 All states and territories have enacted legislation:

- limiting the practice of medicine to registered medical practitioners; and/or

- prohibiting unregistered persons from holding themselves out to be medical practitioners.[26]

2.36 Generally, persons are eligible to be registered as medical practitioners if they:

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[21] Department of Immigration and Multicultural and Indigenous Affairs website, www.immi.gov.au, 'Migrating to Australia – Introduction and Help'.
[22] Ibid.
[23] Media release, *New Arrangements for Overseas-trained Doctors*, Dr Michael Wooldridge, Minister for Health and Family Services, 29 October 1996.
[24] *Overseas doctors seeking permanent residence in Australia*, Form 1062i, Department of Immigration and Multicultural and Indigenous Affairs website, www.immi.gov.au.
[25] Ibid.
[26] For example, see *Medical Practice Act 1994* (Vic), section 62; *Medical Practitioners Act 1983* (SA), sections 30,31; and *Medical Practice Act 1992* (NSW), sections 99, 105.

- have graduated from a medical school accredited by the Australian Medical Council or have successfully completed examinations held by the Council for the purposes of registration as a medical practitioner;
- have completed an internship or period of supervised training in a hospital; and
- are fit and proper to practise as a medical practitioner.[27]

2.37 The registration system is administered by medical registration boards in each state and territory.

2.38 While most registered medical practitioners are general practitioners, specialists including surgeons must also be registered.

2.39 South Australia and Queensland also have specialist medical registers. In South Australia, regulations specify the specialties in which medical practitioners may be registered. These include all nine surgical sub-specialties of the College.[28] Broadly, persons may be registered as a surgeon in any one of these sub-specialties if they:

- are registered as a general medical practitioner;
- are a Fellow of the College or hold a certificate or other document issued by the Australian Medical Council stating that they have attained a satisfactory standard for recognition as a specialist in that speciality; and
- are fit and proper to be registered.[29]

2.40 A person may not hold themselves out to be a specialist in South Australia unless they are registered as a specialist.[30]

2.41 The Commission understands that Queensland's scheme is similar.[31]

2.42 State and territory medical registration boards may grant conditional registration to overseas-trained doctors surgeons that entitles them to work only in a particular position in an area-of-need.

2.43 Prior to 1990, overseas-trained specialists were required to pass an examination aimed at general practitioners to be registered by a state or territory medical board. Since 1990, under a system agreed by Commonwealth, state and territory health ministers, medical boards act on recommendations provided by the College about whether overseas-trained surgeons are either:

- equivalent to Australian-trained specialists; or

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[27]For example, see *Medical Practice Act 1992* (NSW), sections 4 and 13; *Medical Practitioners Registration Act 1996* (Tas), sections 19 and 24; and *Medical Act 1894* (WA), sections 11 and 11AA.
[28]Medical Practitioners Regulations 1983, Schedule 3.
[29]*Medical Practitioners Act 1983* (SA), section 33; Medical Practitioners Regulations 1983, section 8 and Schedule 4.
[30]*Medical Practitioners Act 1983* (SA), section 30.
[31]*Medical Practitioners Registration Act 2001* (Qld), section 111; Medical Practitioners Registration Regulation 2002, Part 3 and Schedule 1.

- if the overseas-trained specialist is proposing to work in an area of need, that he or she is competent to perform the procedures required to be performed in the specific area-of-need position.

2.44 Medical registration boards act in accordance with the College's recommendations about overseas-trained practitioners in most, if not all, cases.

2.45 The Commission understands that being assessed by the College as being equivalent to an Australian-trained surgeon would entitle an overseas-trained surgeon to general and specialist registration.

2.46 More detail in relation the College's assessment of overseas-trained surgeons is provided in Chapter 6.

2.47 The same system for assessing overseas-trained specialists applies for all other medical specialties.

Private practice – Medicare

2.48 In practice, overseas-trained surgeons would only be able to work in private practice if their patients were eligible to receive Medicare rebates.

2.49 Generally, surgical patients are eligible to receive the higher Medicare rebates payable for services provided by specialists where:

- they are private patients of surgeons (ie they are not patients of a public hospital);
- the surgeon is recognised as a specialist under the *Health Insurance Act 1973* (HIA).

2.50 Surgeons will be recognised as a specialist under the HIA if the College gives the Managing Director of the Health Insurance Commission a written notice stating that the surgeon:

- is domiciled in Australia;
- is a Fellow of the College; and
- has obtained, as a result of successfully completing an appropriate course of study, a relevant qualification in relation to the College.[32]

2.51 Overseas-trained surgeons who are domiciled in Australia but who are not College Fellows need to lodge an application with the HIC accompanied by a detailed curriculum vitae, a certified copy of their medical registration, referees' details, copies of qualifications and the relevant fee.

2.52 Overseas-trained surgeons who entered Australia on or after 1 January 1997 first need to obtain an exemption from the Department of Health and Ageing from the ten-year moratorium on granting Medicare provider numbers to overseas trained practitioners.

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[32]Section 3D, *Health Insurance Act 1973* (Cth).

An exemption is available where overseas-trained surgeons propose to work in districts of workforce shortage (generally rural and remote areas, and the public hospital sector).[33] Without an exemption, these surgeons are effectively limited to salaried medical positions.

2.53 The application is referred to a Specialist Recognition Advisory Committee (SRAC), which assesses the application having regard to the following criteria:

- the qualifications of the medical practitioner; and
- the experience and the standing in the medical profession of, and the nature of the practice of, the medical practitioner.

2.54 The SRAC refers the application to the College for a written assessment of the applicant's clinical experience and training. It also requests referees to provide a written reference addressing the criteria above.[34]

2.55 Overseas-trained surgeons who are not domiciled in Australia – that is, temporary resident doctors (TRDs) – also initially need to obtain an exemption from the Department of Health and Ageing from the ten-year moratorium on granting Medicare provider numbers to overseas trained practitioners. As indicated above, an exemption is available where TRDs propose to work in districts of workforce shortage.[35]

2.56 Once TRDs have obtained this exemption, they may apply to the HIC, which refers applications to an Overseas Specialist Advisory Committee (OSAC). An OSAC then assesses the surgeon's application using the same process used for overseas-trained surgeons who are domiciled in Australia – in particular, the matter is referred to the College. However, an OSAC is able to take into account the overall merits of the case, including the area of workforce shortage in relation to which the doctor has been granted an exemption. If granted, specialist recognition will extend for the term of the exemption from the ten-year moratorium, at which time the surgeon needs to re-apply (although if circumstances have not changed, the matter will not be re-submitted to an OSAC or the College).[36]

2.57 SRAC decisions may be appealed to a Specialist Recognition Appeal Committee and OSAC decisions to an Overseas Specialist Appeal Committee.[37]

2.58 There are six SRACs and six OSACs – that is, one for each state, with the ACT combining with NSW and the Northern Territory combining with South Australia. Each SRAC/OSAC and their respective appeal committees have five members. SRACs and OSACs have the same members and meet at the same time. Before making an appointment to these committees, the Minister must request the following bodies to nominate three candidates:

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[33]Information provided by Health Insurance Commission (HIC), 22 October 2001, p2; DHA submission, June 2001, p22.
[34]Information provided by HIC, 22 October 2001, pp1-2.
[35]Information provided by HIC, 22 October 2001, p2; DHA submission, June 2001, p22.
[36]Information provided by HIC, 22 October 2001, p2,3.
[37]Ibid, p3.

- the Australian Medical Association;
- the College;
- the Royal Australasian College of Physicians;
- the Royal Australian College of Obstetricians and Gynaecologists; and
- the Royal Australian College of General Practitioners.[38]

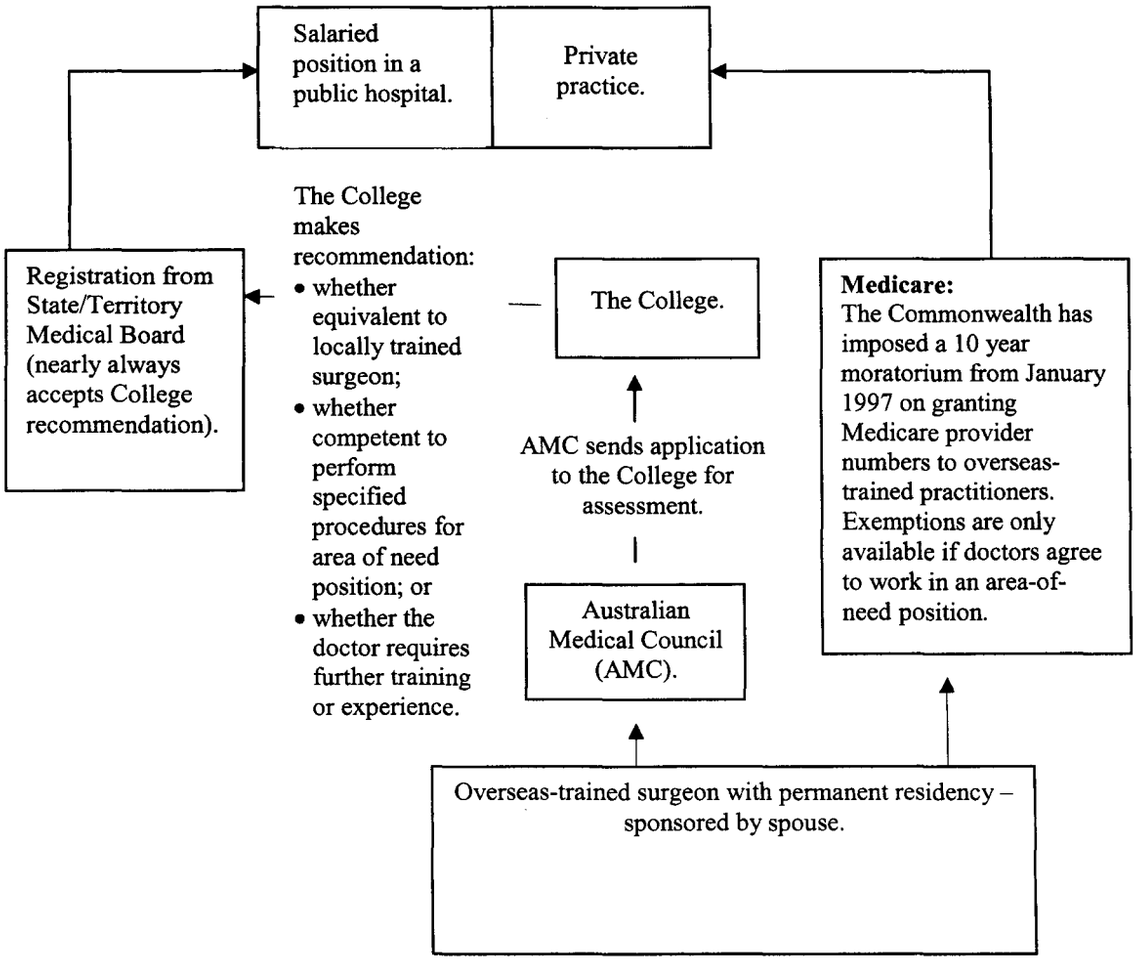
2.59 Generally, the HIC indicated that SRACs/OSACs would be unlikely to act against the advice of the College. It also indicated that, where the College considers that a doctor is deficient in some way, it is generally detailed in its response to the SRAC/OSAC.[39] Unsuccessful candidates also have the right of appeal against the decision to the College Appeals Committee.[40]

Example – overseas-trained surgeon entering Australia under family migration program

2.60 As indicated above, it appears that, given the restrictions on the immigration of doctors, most doctors enter Australia under the family migration program by virtue of having an Australia spouse. Figure 2.2 illustrates the limits on these surgeons entering practice in Australia.

[38]Ibid, pp2-3.
[39]Ibid, p3.
[40]College submission, 13 March 2003, p 9

Figure 2.2: Limits on overseas-trained surgeons entering Australia under family migration scheme entering surgical practice in Australia[41]



[41]Figure 2.2 compiled by the Australian Competition and Consumer Commission.

3. AUSTRALIAN SURGEONS – A STATISTICAL OVERVIEW

Number of surgeons

3.1 In 1998, the Australian specialist workforce comprised 16 490 doctors of whom 2937 were surgical specialists. This represents an increase of 229 surgeons across Australia from 2708 in 1996.[42] General and orthopaedic surgeons account for 60 per cent of the workforce. In 1998, the number of practitioners in the different surgical sub-speciality areas in Australia were:

Table 3.1: Number of surgeons in each surgical sub-specialty[43]	
General surgery	1028
Cardiothoracic surgery	97
Neurosurgery	102
Orthopaedic surgery	714
Otolaryngology – head and neck surgery	302
Paediatric surgery	77
Urology	222
Vascular surgery	140
Plastic and reconstructive surgery	256

3.2 As at December 1998, there were 15.6 surgeons per 100 000 persons, which represents a total increase of 0.9 surgeons per 100 000 persons, from 14.7 surgeons per 100 000 persons in 1996.[44]

[42] AIHW, *Medical Labour Force 1996*, Table 12, p24.
[43] AIHW, *Medical Labour Force 1998,* Table 16, p25.
[44] AIHW *Medical Labour Force 1998,* Table 54 (supplementary tables).

3.3 As at December 1998, the number of surgeons in each state and territory were:

Table 3.2: Number of surgeons by state and territory in 1998[45]		
	Number in each state and territory	Number of surgeons per 100 000 population in each state and territory
New South Wales	996	15.6
Victoria	808	17.2
Queensland	471	13.5
South Australia	280	18.8
Western Australia	254	13.7
Tasmania	57	12.1
Northern Territory	21	10.8
Australian Capital Territory	52	16.8
Total	*2708*	

3.4 As at 1998, the number of surgeons per 100 000 population in Australia for each sub-speciality was as set out in Table 3.3.

Table 3.3: Number of surgeons in each surgical sub-speciality per 100 000 persons[46]	
Sub-specialty	**Surgical specialist per 100 000 population**
General surgery	5.5
Cardiothoracic surgery	0.5
Neurosurgery	0.5
Orthopaedic surgery	3.8
Otolaryngology – head and neck surgery	1.6
Paediatric surgery	0.4
Plastic surgery	1.4
Urology	1.2
Vascular surgery	0.7

[45] AIHW, *Medical Labour Force 1998,* Table 16, p25 and Table 5, p15.
[46] AIHW, *Medical Labour Force 1998*, Table 62.

3.5 In 1998 the number of surgeons in each of the different surgical sub-speciality areas by state and territory were:

Table 3.4: Number of surgeons in each surgical sub-specialty by state and territory[47]

Specialty	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
General surgery	358	288	180	88	75	17	14	8
Cardiothoracic surgery	32	33	15	5	6	1	0	3
Neurosurgery	35	28	11	14	6	3	0	5
Orthopaedic surgery	242	170	119	87	69	11	3	13
Otolaryngology – head and neck surgery	99	79	49	24	36	4	3	8
Paediatric surgery	25	23	9	8	6	3	0	3
Plastic surgery	77	82	30	28	26	7	0	6
Urology	72	62	36	19	21	9	0	3
Vascular surgery	57	43	22	6	8	1	0	3

Change in number of surgeons in each sub-specialty between 1996 and 1998

3.6 Between 1996 and 1998, the number of surgeons per 100 000 persons increased slightly in four surgical sub-specialties. In particular, the number of surgeons per 100 000 persons:

- increased by 0.6 per cent in general surgery (from 4.9 to 5.5 surgeons per 100 000 persons);
- remained the same in cardiothoracic surgery (at 0.5 surgeons per 100 000 persons);
- decreased by 0.1 per cent in neurosurgery (from 0.6 to 0.5 surgeons per 100 000 persons);
- increased by 0.2 per cent in orthopaedic surgery (from 3.6 to 3.8 surgeons per 100 000 persons);
- decreased by 0.1 per cent in otolaryngology – head and neck surgery (from 1.7 to 1.6 surgeons per 100 000 persons);
- remained the same in paediatric surgery (at 0.4 surgeons per 100 000 persons);

[47] AIHW, *Medical Labour Force 1998,* Table 16, p25.

- increased by 0.2 per cent in plastic surgery (from 1.2 to 1.4 surgeons per 100 000 persons);
- increased by 0.1 per cent in urology (from 1.1 to 1.2 surgeons per 100 000 persons); and
- remained the same in vascular surgery (at 0.7 surgeons per 100 000).[48]

Gender distribution of surgeons

3.7 In 1998, 96 per cent of surgeons in Australia were male. The number of male surgeons increased from 2613 in 1996 to 2832 in 1998. Over the same period, the number of female surgeons increased from 95 in 1996 to 106 in 1998.[49]

3.8 Generally, the Australian Institute of Health and Welfare (AIHW) indicated in its *1998 Medical Labour Force Survey* that female medical students are much more likely than males to choose general practice as a career path and less likely to select speciality practice, especially surgery.[50]

3.9 In 1998, the number of male and female surgeons per surgical sub-speciality were:

Table 3.5: The number of male and female surgeons per surgical sub- speciality[51]

Surgical sub-specialty	Male	Female	Proportion of female surgeons
General surgery	991	37	4%
Cardiothoracic surgery	92	5	5%
Neurosurgery	93	8	8%
Orthopaedic surgery	706	8	1%
Otolaryngology – head and neck surgery	289	13	4%
Paediatric surgery	68	9	12%
Plastic surgery	241	15	6%
Urology	217	6	3%

[48]Figures compiled from: AIHW, *Medical Labour Force 1998,* Table 62 (supplementary tables); AIHW, *Medical Labour Force Survey 1996,* Table 54 (supplementary tables).
[49]Figures compiled from: AIHW, *Medical Labour Force 1998*, Table 17, p26; AIHW, *Medical Labour Force 1996*, Table 7, p12.
[50]AIHW, *Medical Labour Force 1998*, p5.
[51]AIHW, *Medical Labour Force 1998*, Table 17, p26.

Vascular surgery	135	5	4%
Total	*2832*	*106*	

Hours worked by surgeons

3.10 In 1998, the highest proportion of doctors working 80 hours or more per week was surgeons (14.9 per cent).[52] In addition, approximately 17 per cent of surgeons were working between 65-79 hours per week.

3.11 Table 3.6 shows the weekly hours worked by surgeons.

Table 3.6: Hours worked by surgeons per week[53]

Hours per week	Proportion of surgeons
1-19	5%
20-34	7%
35-49	19%
50-64	37%
65-79	17%
80 or more	15%

3.12 In 1998, 16.8 per cent of male surgeons worked between 65-79 hours per week, while 14.7 per cent of female surgeons worked between the same hours. In addition, 15 per cent of male surgeons worked 80 or more hours per week, compared to 12.9 per cent of female surgeons.[54]

3.13 Table 3.7 below shows surgeons' weekly hours by sub-specialty. In particular, the surgical sub-specialties where more than 30 per cent of practitioners reported working more than 65 hours per week were general surgery, cardiothoracic surgery, neurosurgery, orthopaedic surgery, paediatric surgery, urology and vascular surgery.

Table 3.7: Weekly hours by surgical sub-specialty in 1998[55]

Surgical sub-specialty	Total hours worked per week						% of surgeons working more than 65 hours per week
	1-19	20-34	35-49	50-64	65-79	80+	

[52] AIHW, *Medical Labour Force 1998*, p7.
[53] Figures compiled from: AIHW, *Medical Labour Force 1998*, Table 9, p19.
[54] AIHW, *Medical Labour Force 1998,* Table 9, p19.
[55] AIHW, *Medical Labour Force 1998*, Table 64 (supplementary tables).

Table 3.7: Weekly hours by surgical sub-specialty in 1998[55]							
Surgical sub-specialty	**Total hours worked per week**						**% of surgeons working more than 65 hours per week**
	1-19	**20-34**	**35-49**	**50-64**	**65-79**	**80+**	
General surgery	70	56	187	371	168	176	33.5
Cardiothoracic surgery	1	5	16	34	25	17	42.8
Neurosurgery	4	5	10	46	24	13	36.2
Orthopaedic surgery	31	70	130	260	124	99	31.3
Otolaryngology – head and neck surgery	18	29	89	110	36	19	18.3
Paediatric surgery	3	8	17	22	12	14	33.9
Plastic surgery	12	14	43	118	39	30	26.9
Urology	7	13	47	83	45	27	32.4
Vascular surgery	1	7	23	48	18	42	43.3

Age of surgeons

3.14 Table 3.8 shows the age profile of surgeons in 1998. In particular, most surgeons were in the 45-54 year age group.

Table 3.8: Age of surgeons in 1998[56]	
Age	**Proportion of surgeons**
Less than 35 years	2%
35-44 years	25%
45-54 years	31%
55-64 years	28%
65-74 years	12%
More than 75 years	2%

[56]Figures compiled from: AIHW, *Medical Labour Force 1998*, Table 63 (supplementary tables).

4. HISTORY OF SURGICAL TRAINING IN AUSTRALIA

Origins of the College

4.1 In the 1920s – as is the case today, except in South Australia and Queensland – there was no direct statutory restriction on who may perform surgery other than that they be registered as a medical practitioner under state or territory legislation.

4.2 Moreover, universities awarded (and still generally award) medical undergraduates a Bachelor of Medicine and a Bachelor of Surgery and it appears that many general practitioners (perhaps not surprisingly) considered that the latter entitled them to operate. The only ways for a specialist surgeon to formally distinguish him or herself from a general practitioner was to become a Fellow of one of the British, Irish or American surgical colleges or obtain a higher university surgical degree. [57] Probably for obvious geographical reasons, many if not most surgeons did not or could not take up the former option.[58]

4.3 Specialist surgeons of the time consequently became concerned about:

> A growing disregard by younger practitioners of recognised ethics of Surgical Practice, combined with a spirit of commercialism tending to degrade the high traditions of the surgical profession.
>
> Difficult and dangerous operations are undertaken by practitioners who have not been properly trained in surgical principles and practice, and who divide fees with colleagues who refer the patients to them. They also operate in small and inadequately equipped hospitals which have recently sprung into existence in large numbers. The public has no means of judging the competency of these so-called surgeons... and the efficiency of these hospitals. It is felt that steps should be taken to counteract these conditions.
>
> It is proposed that a body should be formed which would have authority to indicate that its members were properly qualified to practise surgery and its various specialties, and to hold positions as such on hospital staffs.
>
> It is suggested that Senior Surgeons and Surgical Specialists, who could not be regarded as having any personal ends in view, should initiate such a body. Its objects would be to endeavour to raise the status of surgery and check its practice by those who are not adequately trained, and also to improve hospital standards. [59]

4.4 However, the formation of an exclusive surgical college was generally opposed by the general practitioners who dominated the medical profession for two reasons: (i) that those supporting the college were 'creating a self-appointed aristocracy of surgeons

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[57] The Royal College of Surgeons of England, the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Ireland and the American College of Surgeons. American Fellowships were rare.

[58] Of the 41 Founders of the College, only 13 had English Fellowships, with one Irish Fellowship and one from the Edinburgh College; *The Mantle of Surgery – The First Seventy-Five Years of the Royal Australasian College of Surgeons*, A.W. Beasley, published by the Royal Australasian College of Surgeons, 2002, p53.

[59] Extract from letter from G.A Syme, Hamilton Russell and H.B Devine to surgeons in Australia and New Zealand, 19 November 1925, ibid, p18. It appears that the authors of the letter considered that senior surgeons and surgical specialists would not be regarded as having any personal interest in the establishment of the College because they were aged; ibid, p54.

and destroying the livelihood of many who would be excluded'; and (ii) a new college would threaten the unity of the then British Medical Association.[60]

4.5 However, in 1927, the College was formed. Fellowship was initially open to surgeons who possessed at least five years of post-graduate training and (from 1932) a senior surgical degree or diploma.[61] Post-graduate training soon effectively meant an apprenticeship to a senior surgeon, although other work (e.g. research) was recognised.[62]

4.6 These entry requirements combined the approaches of the American College of Surgeons and the British and Irish surgical colleges. The former relied primarily on post-graduate training, in the belief that surgical competency was best determined by assessing a surgeon's record of operations. The latter colleges relied on higher surgical degrees to do this.[63]

Accreditation of hospital posts

4.7 While the College recognised from its earliest days the need to improve hospital standards so as to improve training standards, it was not until the mid-1940s that it made significant progress in this area, and not until the early 1960s that a systematic inspection and approval system for hospital posts was established.[64] Hospital post inspections became more important with the introduction of structured training programs from the 1970s in the various surgical sub-specialties that had developed in the previous decades.[65]

4.8 The College's current system for accrediting hospitals and hospital posts is detailed at paragraphs 6.83 - 6.106.

4.9 A problem that emerged in response to the College's 1940's initiatives to commence accrediting hospital posts for training purposes was that nearly all posts in Sydney hospitals were at that stage part of the University of Sydney's Master of Surgery degree (which included an apprenticeship requirement). However, this resistance was, for some reason, brief.[66]

Examinations

4.10 Upon the establishment of the College, surgeons were only required to provide documentary evidence of their training to a credentialing committee which assessed its adequacy. From 1934, surgeons who had completed their post-graduate training were interviewed by a board of censors to test their knowledge and ability. From 1946, the College replaced this interview with an exit examination – which evolved

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[60] *The Shaping of the RACS 1920-1960*, Colin Smith, Royal Australian College of Surgeons Handbook, 1995, p19.
[61] *The Mantle of Surgery,* op. cit, p56. Higher surgical degrees included a Master of Surgery from an Australasian university; ibid, p86. See also *The Shaping of the RACS 1920-1960*, op.cit n.64, p17.
[62] *The Mantle of Surgery,* op cit, p56.
[63] Ibid, p55-56.
[64] *The Shaping of the RACS 1920-1960*, op.cit, pp17-18, 40, 42.
[65] *The Mantle of Surgery,* op. cit ,p152.
[66] *The Shaping of the RACS 1920-1960*, op.cit. pp40-41.

into today's Part 2 exam taken, with the exception of general surgery, in the final year of advanced surgical training (see paragraph 6.72).[67]

4.11 As indicated above, applicants for College Fellowship were also required to possess a senior surgical degree. Between 1931 and 1946, the Royal College of Surgeons of England periodically conducted its Fellowship exam in Australia and passing this exam satisfied the surgical degree requirement, in addition to actually completing a senior surgical degree at an Australian university.[68] Indeed, the University of Sydney refused to co-operate with the English college, whom it considered a competitor.[69]

4.12 From 1949, the College decided that it could no longer rely on qualifications awarded by other bodies whose standard it could not guarantee. It therefore required prospective surgeons to pass its own entry examination – which evolved into today's Part 1 exam taken in the second year of basic surgical training. This displaced the English Fellowship and the Australian senior surgical degrees (which became research degrees).[70] In 2000, the College introduced a structured Basic Surgical Training program which included the Part 1 exam (see paragraph 6.32).

The College becomes dominant

4.13 At the end of the College's first quarter-century of existence, many surgeons were not College Fellows. For example, in 1955 in Queensland, 38 surgeons under the age of 50 possessed the English Fellowship and only 17 the Australasian.[71] In particular, the requirement to sit the Part 2 examination was a significant disincentive to seeking Fellowship for many established surgeons, as it was for newer surgeons returning from England with the English Fellowship (which was by then effectively competing with the College in the field of surgical qualification).

4.14 During the 1950s, the College temporarily relaxed this requirement in various ways so as to attract these surgeons into the College. While being criticised at the time for indecision about standards, this relaxation appeared to largely succeed in achieving its immediate goal and, in the longer term, helped to establish the College's dominance in Australia. In 1992, the College decreed that its Fellowship would be the only valid surgical diploma in Australasia.[72]

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[67] *The Mantle of Surgery,* op. cit pp56, 86.

[68] Ibid, pp59-60, 86-87; *The Shaping of the RACS 1920-1960*, op cit, p23. It appears the motive of the English college in offering to conduct its Primary exam in Australia was to ward off the influence of the American college.

[69] *The Shaping of the RACS 1920-1960*, op cit, pp25-26.

[70] *The Mantle of Surgery,* op cit, p87; *The Shaping of the RACS 1920-1960*, op cit, p29.

[71] *The Mantle of Surgery,* op. cit, p88; *The Shaping of the RACS 1920-1960*, op cit, p27.

[72] *The Mantle of Surgery,* op. cit, Chapter 6 and p241. See also *The Shaping of the RACS 1920-1960*, op cit, pp29-30, 35-37.

5. THE COLLEGE

5.1 The College is an Australian public company limited by guarantee. It was established in 1927 and incorporated in 1930 in Melbourne, Victoria.

5.2 The objectives of the College are:

- training and examination of doctors seeking to become surgeons through Fellowship of the College;
- continuing education and maintenance of standards of surgical practice;
- fostering surgical research;
- involvement in the community in promulgating and achieving high standards of health; and
- developing good international relationships with a view to fostering high surgical standards.

Structure and management of the College

The Council

5.3 The governing body of the College is a Council of:

- 16 Fellows who are elected to the Council for a period of three years and who are eligible for re-election at the end of those three years; and
- nine co-opted Fellows who represent specialty societies and other interests. Each of the geographic regions and surgical sub-specialties is represented on the Council.

5.4 The Council Executive is elected annually by the members of the Council and comprises the President, Vice President, Honorary Treasurer, Censor-in-Chief, and the Chairman of the Court of Examiners, Chairman of the Board of Continuing Professional Development and Standards and the Chairman of the Board of Basic Surgical Training.

5.5 The Council has the power under the College's Memorandum and Articles of Association to make rules and regulations in relation to a number of matters including:

- the admission by examination of persons as Fellows of the College;
- the election of persons as Honorary Fellows of the College;
- the creation and maintenance of faculties, divisions, sections and other groupings within the College;
- the promulgation of the duties and functions of all persons in the employ of the College;

- the creation, appointment, direction and dissolution of committees;
- the maintenance and amendment from time to time of the register of Fellows;
- the discipline, suspension and expulsion of Fellows and other procedures (including imposing any penalties or fines) as is necessary to uphold the ethics, dignity, good reputation, standards and purposes of the College; and
- the procedures for the hearing of any appeal or review of any decision of a Complaints Committee Council (Regional or Complaints Committee), including the establishment of special committees for that purpose, proceedings at and conduct of meetings for that purpose, and any other incidental procedures or matters.

5.6 The management of the College is overseen by the Chief Executive, who is responsible for advising the Council and providing the management infrastructure to ensure that policy decisions can be implemented without the direct involvement of Fellows.

Committees

5.7 The College has established a range of committees and boards to assist it to perform its functions. Committees and boards relevant to its application for authorisation are set out in Table 5.1 below. An overview of the College's structure is also provided in Figure 5.1 below.

Table 5.1: Committees of the College relevant to its application for authorisation[73]

Committee	Function
Executive Committee of Council	Reports directly to and acts for the Council between meetings. It has the power to deal with all issues. With limited exceptions, other committees report to the Council through the Executive Committee.
Education Policy Board (EPB)	The EPB is the senior, overarching education policy forum. The Board of Basic Surgical Training, Board of Advanced Surgical Training and the Court of Examiners fall under it.
Board of Basic Surgical Training (BBST)	Responsible for all activities affecting the selection, education and training and examination of Basic Trainees. Regional sub-committees act as BBST's local agent regarding the selection and training of

[73]Table compiled from the College's supporting submission to the application for authorisation, 30 March 2001, (Attachment 1).

	basic trainees. Sub-committees also report to the BBST on the three basic trainee skills courses (see paragraph 6.27) and each of the various examinations for basic trainees (see paragraphs 6.32-6.34).
Board of Advanced Surgical Training (BAST) (formerly the Censor-in-Chief's Committee)	Responsible for all activities affecting the selection, training and examination of advanced trainees in consultation with Specialty Boards and the BBST.
Speciality Boards	All nine surgical specialty boards report through and have representation on the BAST. Each of these Boards has Regional Sub-Committees.
Court of Examiners	Reports to and has representation on the Education Policy Board but may inform Council directly of the Part II examination results. The Court of Examiners consists of examiners from each of the surgical sub-specialities. The role of the Court of Examiners is to organise, conduct and advise on the format of the Part II Examination in the relevant surgical discipline.
Continuing Professional Development and Standards Board	Reports to the Executive Committee. It has a close relationship with, and representation on, the Education Policy Board in relation to education matters, it administers all aspects of post Fellowship training and professional development and it has an overarching role in monitoring and influencing health policy and surgical standards.

College Fellows

5.8 In February 2002, the AMC reported that there were 5176 Fellows of the College, of which 4053 reside in Australia and 661 in New Zealand. Approximately 90 per cent of surgeons practising in Australia and New Zealand are Fellows of the College.[74]

Affiliated societies

[74] Australian Medical Council, *Accreditation Report, Review of the Education and Training Programs of the Royal Australasian College of Surgeons,* Specialist Education Committee, February 2002, p5.

5.9 The College has established specialty boards in all surgical subspecialties. These specialty boards are responsible for significant elements of the College's training and assessment processes, including:

- determining the content, structure and duration of advanced surgical training;
- the accreditation of advanced surgical training posts;
- the selection of advanced surgical trainees; and
- the assessment of advanced surgical trainees, including their eligibility to sit the Part 2 examination.

5.10 However, the Commission understands that, for the following surgical sub-specialties, the members of the College specialty board are largely nominated by the relevant affiliated surgical society (listed in Figure 5.1 below):

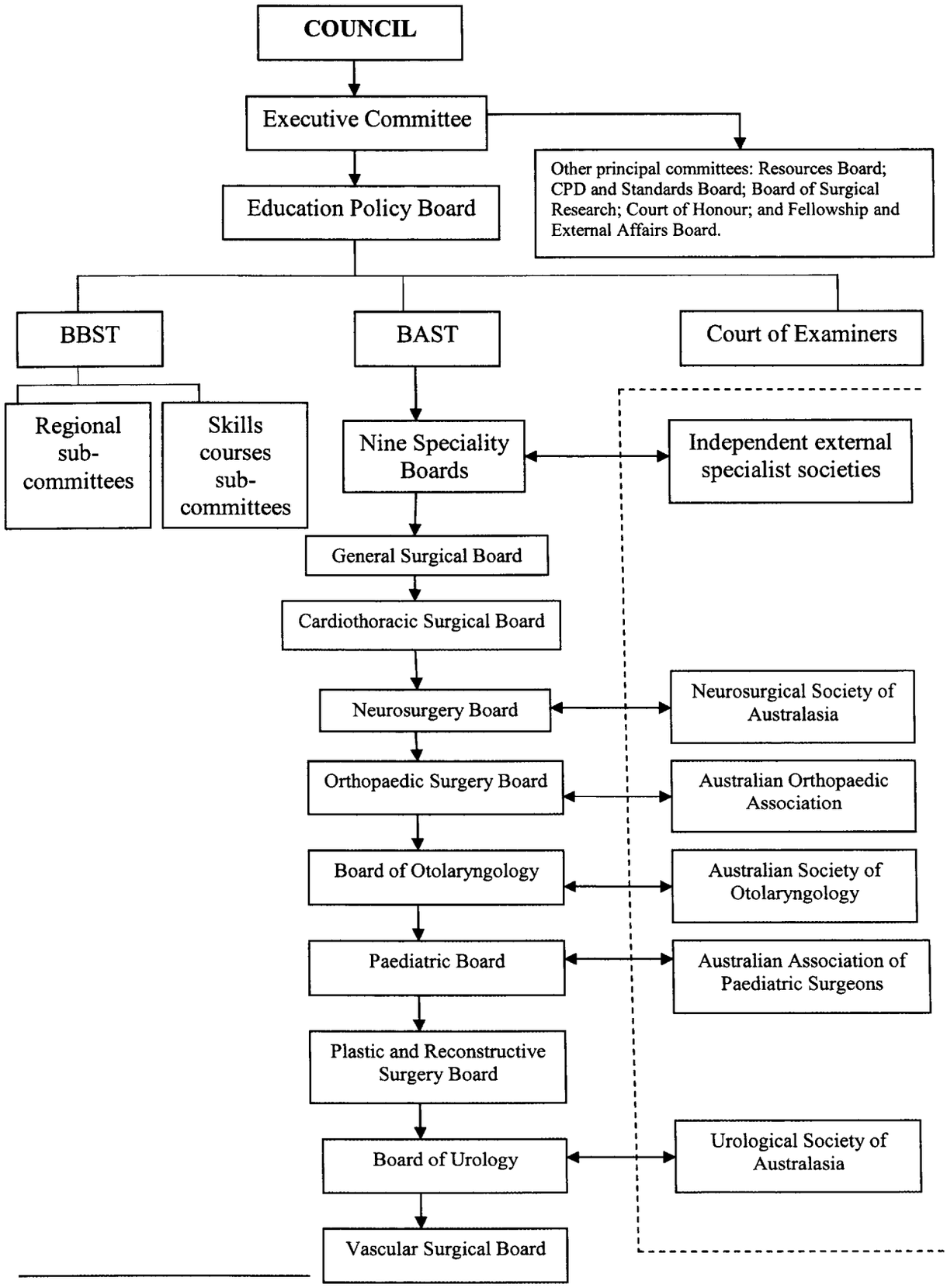
- orthopaedic surgery;
- urology;
- otolaryngology – head and neck surgery;
- neurosurgery; and
- paediatric surgery.

5.11 The Commission understands that the College has effectively contracted out the responsibilities of the specialty board to the relevant surgical society. While the College describes these societies as being 'affiliated' with it, the Commission understands that, in reality, they are independent external organisations that are not formally part of the College in any way (although they share many of the aims and objectives of the College). Rather, their only formal link with the College is through the delegation of the administration of the training program in relevant surgical sub-specialty. The Commission understands that surgical societies also influence the appointment of Fellows to the College's Court of Examiners, which controls the Part 2 exam, as well as the format and content of this exam.

5.12 The Commission also understands that, in the surgical sub-specialties listed above:

- the relevant surgical society has established a training, accreditation and education committee to oversee the responsibilities delegated to it; and
- this committee typically comprises the persons nominated by the surgical society to the College specialty board.

Figure 5.1: Overview of the structure of the College[75]



[75]Compiled by the Commission from the College's supporting submission to the application for authorisation, March 2001, Attachment 1.

6. THE COLLEGE'S SURGICAL TRAINING PROGRAM AND PROCESS FOR ASSESSING OVERSEAS-TRAINED SURGEONS

6.1 The College seeks authorisation of its activities with respect to:

- selecting, training and examining basic surgical trainees;
- selecting, training and examining advanced surgical trainees in all nine surgical sub-specialities;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

6.2 The application for authorisation is made on behalf of:

- the College, its officers, employees, current Fellows, as well as the current members of the College's affiliated specialist societies and associations; and
- pursuant to section 88(10), all future College Fellows, as well as future members of the College's affiliated specialist societies and associations.

6.3 The College is seeking authorisation under the state and territory Competition Codes, as well as the Act.[76]

6.4 A list of the specialist societies on whose behalf the application is made is at Attachment A.

6.5 The College is seeking authorisation to give effect to a contract, arrangement or understanding, a provision of which has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

The selection, training and examination of trainees

6.6 The College offers basic surgical training (covering surgical theory and practice common to all surgical sub-specialties) and advanced surgical training. Advanced surgical training is offered in the areas of general surgery, cardiothoracic surgery, neurosurgery, orthopaedic surgery, otolaryngology – head and neck surgery, paediatric surgery, plastic and reconstructive surgery, urological surgery and vascular surgery.

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[76]Letter from College, 7 September 2001.

6.7 College Fellows working primarily in public hospitals provide surgical training. The College has complete control over trainee examinations, but it depends on the cooperation of hospitals to ensure adequate training.

6.8 Trainees move through a minimum of two years of basic surgical training and a minimum of four years of advanced surgical training in the relevant nominated surgical specialty. Surgical training becomes increasingly complex as trainees progress through the program. Trainees are supervised by College Fellows and training takes place either at College accredited hospitals (basic training) or in College-accredited hospital posts (advanced training).

6.9 The stated objective of the College's selection, training and examination program is to ensure that trainees develop the necessary knowledge, skills and attitude to become a:

- medical expert;
- communicator with patients and their families;
- collaborator with other medical practitioners and health care professionals;
- manager of personal resources;
- health advocate;
- scholar and teacher; and
- health care professional.

Selection of trainees for basic surgical training

6.10 Applicants for the basic surgical training program must possess a MB BS (Bachelor of Medicine and Bachelor of Surgery) or equivalent and be registrable in Australia and New Zealand. That is, the applicant must have attended a medical school which has received accreditation from the AMC and have one year of post graduate experience (internship). Trainees usually apply to the College for admission to the program during their first year in an internship.

6.11 Until the 2001 intake, the number of trainees accepted into the College's basic training program was unlimited. Any junior doctor in any hospital with an interest in a surgical career could apply for the basic training program. However, with the introduction of the restructured training program from 2000, basic surgical training places are only available to qualified applicants who obtain a position in an accredited hospital. The final intake into the old basic surgical training program was in 2000, a condition of entry being that trainees complete training by the end of 2003.

6.12 Under the new program, applicants are required to apply simultaneously to the College for a place in the basic training program and to an accredited hospital (or hospital authority) for a hospital training post. The appropriate hospital authority makes the appointment to a hospital. The Hospital Supervisor of Basic Surgical Training is normally a member of the hospital selection committee.

6.13 Applicants are selected by the Board of Basic Surgical Training of the College on the basis of:

- a structured curriculum vitae;
- their performance at a semi-structured interview; and
- referee reports.

6.14 The Board determines a score for performance in each of the individual components listed above. Applicants are ranked according to the total of weighted scores in each of the above components. Members of the interview selection panel do not have access to the applicant's score from their curriculum vitae or referee reports.

6.15 The College establishes a cut off-point by deciding what an acceptable overall score would be. Applicants scoring above this are then ranked nationally. Positions are offered in order of merit. Applicants are made aware of the selection tools used in the selection process, and the weighting of each, which culminates in the overall score.

6.16 For the 2002 intake, the number of basic surgical trainees selected was limited to 180.[77] The Commission understands that this limit reflects:

- the availability of places in the three basic training skills courses (detailed in paragraph 6.27), which is dependent on the number of trainers from the College; and
- the number of advanced surgical training places likely to be available when the successful applicants complete basic surgical training.

Interviews

6.17 The College has developed an interview pro-forma which is followed for each applicant. The interview runs for approximately 20 minutes and consists of three questions which address the following key attributes:

- motivation (including surgical goals, self-evaluation, training and organisation);
- medical ethics;
- conflict; and
- communication.

6.18 At the conclusion of the selection interview, each interviewer completes an individual rating form which records the applicant's score for each attribute. The interview panel then reaches a consensus rating for each of the key attributes on a panel rating form. The process of reaching a consensus commences with both interviewers reading out their comments for each attribute, followed by the numerical score they have given. The interviewers then must reach an agreed score. An average of the two

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[77]Royal Australasian College of Surgeons, *Interviews August 2001 – Notes for Interviewers.*

scores is not an acceptable method to achieve the consensus score. If a consensus cannot be reached, even after recalling the applicant, arrangements are made for a new panel to re-interview the applicant as soon as possible. The panel rating form is the official record of the interview, and is provided to the Board for consideration. The comments and scores on the individual rating forms, which must not be altered after consensus is reached, are used as quality assurance data for the interview process.

Successful applicants

6.19 If an applicant is selected for the basic surgical program, and the applicant is successful in obtaining an accredited hospital post, they must register with the College as a basic surgical trainee. Trainees are required to re-register with the College each year. Re-registration is subject to satisfactory in-training assessment reports (see paragraph 6.30), and if necessary, the trainee will be re-interviewed. A trainee is eligible to remain registered:

- for a maximum of the equivalent of four years basic surgical training; or
- for a maximum of four attempts at the Part 1 (Basic Surgical Training) Examination (discussed at paragraph 6.32 below),

whichever occurs sooner.

6.20 In relation to the registration period, the College submits that four attempts at the Part 1 (Basic Surgical Training) Examination or a maximum of three attempts to gain an Advanced Surgical Training place provides trainees with sufficient opportunities to demonstrate their credentials for gaining an Advanced Surgical Training place.[78]

Training of basic surgical trainees

6.21 The duration of basic surgical training is a minimum of two years and a maximum of four years. Over this period, trainees acquire knowledge of the theory and practice of surgery in areas common to all branches of surgery. The program is comprised of four components:

- clinical experience;
- distance learning;
- skills courses; and
- assessment and examinations.

6.22 Basic trainees are able to undertake part-time or interrupted training (for example to undertake research, for ill-health or for parenting) at any time during basic training.[79]

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[78]College submission, 14 March 2002, p14.
[79]College submission to the Australian Medical Council for Accreditation, May 2001, p22.

Clinical experience

6.23 The basic surgical training program may be described as an 'apprenticeship', the practical aspect of which takes place in a post in an accredited hospital and involves one to one relationships between the trainee and College Fellows throughout the program. Trainees normally rotate through a series of training posts, each of approximately three months in length, in order to gain exposure to as many surgical sub-specialties and related disciplines as possible.

6.24 Trainees are required to occupy approved surgical posts for a minimum period of 12 months (that is, four rotations). For the remaining 12 months, trainees must spend at least three months in an emergency department, and a minimum of two months in a general intensive care or high dependency unit that is supervised by a qualified surgeon, anaesthetist or intensivist. The balance may be spent in surgical, medical or basic science posts, or in approved research projects.

6.25 A period of up to three consecutive months in approved general practice may also be accepted upon consideration by the Chairman of the Board of Basic Surgical Training.

Distance learning

6.26 Basic surgical trainees must also complete a Distance Learning Program during the first 18 months of the basic surgical training, consisting of 22 education modules. The education program is coordinated through the College's basic surgical training on-line website. The program is based on the application of the basic sciences to clinical practice. The program covers anatomic and biological basis of disease, basic surgical practice and generic aspects of surgery. Trainees are also required to cover a comprehensive recommended reading list.

Skills courses

6.27 Basic surgical trainees are required to complete three skills courses. These are:

- the Basic Surgical Skills course undertaken during the first six months of the training program. The course is designed to give the trainee the opportunity to practise skills such as suturing under close supervision. Courses are conducted in each State;

- the Early Management of Severe Trauma course completed during the first year of training. This is an intensive course in the management of trauma victims in the first one to two hours following injury. It entails two and a half days of structured teaching with opportunities for development and practice of necessary skills; and

- the Care of the Critically Ill Surgical Patients course undertaken in the first six months of the second year of the program. This course is designed to advance the practical, theoretical and personal skills necessary for the care of critically ill surgical patients. It involves three days of instruction and experience, partly using simulators to demonstrate priorities for treatment of surgical patients.

6.28 Trainees are also expected to participate in a range of hospital resident training programs including demonstrations, discussions and seminars on basic surgical sciences, clinical meetings, and audit review within the hospital.

Assessment and examination of basic surgical trainees

6.29 In addition to successfully completing the distance learning program and skills courses, basic surgical trainees must also pass the Part 1 Basic Training Exam. The performance of basic trainees is also assessed via continuous clinical in-training assessment reports.

In-training assessment reports

6.30 Trainees' surgical supervisors prepare continuous clinical in-training assessment reports of their performance in each rotation they undertake. Where a trainee has several supervisors, each supervisor may prepare an assessment report. The Hospital Supervisor of Surgical Training then amalgamates the assessments to produce a single in-training assessment report for the trainee. Alternatively, supervisors may discuss the trainee's performance with the Hospital Supervisor of Surgical Training, who writes a single assessment report. The aim of the reports is to monitor the performance of basic trainees across a range of professional activities, namely:

- Clinical skills – assessment of history, use of investigations, judgement and post-operative care;
- Technical skills – surgical laparoscopy/endoscopy, open surgery as a surgical assistant;
- Academic performance – knowledge of subject, case presentations, learning and teaching;
- Attitudes – communication with patients, cooperation with staff, self motivation and organisation, reliability and punctuality, stress responses, acceptance of criticism; and
- Research – research can be credited towards surgical training.

6.31 The trainee receives a rating from their supervisor in each activity, ranging from poor to excellent. The trainee must receive scores of 3 (satisfactory) or better in each activity. An overall rating is then assigned. A minimum of 52 weeks of satisfactory assessment must be achieved during basic surgical training. Further training is required if a trainee fails to meet this requirement.

Part 1 Basic Training Examination

6.32 The Part 1 Basic Training Examination package is designed to ensure that the basic surgical trainee, regardless of the intended surgical specialty, has acquired the knowledge of the scientific foundations of surgery. The examination is overseen by the Board of Basic Surgical Training. Trainees are only eligible to sit the Part 1 Examination in the second year of the basic surgical program, and after completing the distance learning component of the program.

6.33 Specifically, the Part 1 Examination consists of:

- The Multiple Choice Questions Examination consisting of three papers, each having 120 multiple choice questions to be completed within two and a half

hours. These questions are drawn from the disciplines of anatomy, physiology and pathology. A trainee is required to obtain a minimum standard in each of the three disciplines, at the same sitting, before a trainee is deemed to have passed the multiple choice examination; and

- The Objective Structured Clinical Examination consisting of 20 'stations' at which the trainee spends five minutes undertaking tasks that may include:
  - history taking and examinations;
  - demonstration of practical technical skills;
  - the application of basic science knowledge; and
  - data acquisition and analysis.

6.34 The Part 1 Multiple Choice Examination is held in February/March, June/July and October/November each year in all Australian capital cities except Canberra and Darwin, as well as, subject to sufficient numbers, Auckland, Wellington, Christchurch, Dunedin, Singapore, Kuala Lumpur and Hong Kong. The pass rate of the Part 1 Multiple Choice Examination from 1995 to 2000 is provided in Table 6.3.

6.35 Also subject to there being a sufficient number of candidates, the Objective Structured Clinical Assessment is held in February/March and June/July each year. The pass rate of the Part 1 Structured Clinical Examination from 1995 to 2000 is provided in Table 6.4.

Basic surgical training experience portfolio

6.36 The trainee is also required to complete a basic surgical training experience portfolio for each rotation to record the breadth and depth of hospital training, as well as the number and type of procedures undertaken by the trainee. The portfolios are forwarded to the College at the conclusion of each rotation. The Commission understands that trainee portfolios do not form part of a trainee's assessment. Rather, they are collected by the College to evaluate the basic surgical program and to identify any trends arising from trainee progression and hospital experiences.

6.37 The portfolios contain basic demographic data and information about each of the following elements of training:

- Basic Surgical Training Program, including access to supervisors and education modules;
- ambulatory care experience;
- operative experience;
- procedural experience;
- operative/procedural log;

- in-patient management experience which includes breaking bad news and the management of dying patients;
- academic activity;
- courses attended;
- teaching involvement; and
- personal growth.

Years 3 and 4

6.38 As previously discussed, basic surgical trainees have a minimum of two years and a maximum of four years to complete the basic training program. During this time they remain in hospitals accredited for the purposes of basic training. After successfully completing basic surgical training, a trainee selects an area of surgery in which they wish to specialise. A basic surgical trainee must then win a place in the relevant advanced surgical training program. Applications for advanced surgical training will only be accepted from registered trainees.[80]

6.39 Trainees remain registered basic surgical trainees from the time they have completed the minimum requirements of the training programme until they have won an advanced training position (or exited from surgical training, ie the four year rule).

6.40 For 2001, Table 6.6 shows the average number of months since trainees completed basic surgical training, per surgical sub-speciality, before they were accepted into advanced surgical training.

6.41 The Commission understands that a key aim of the new basic surgical training program – which aligns the number of basic surgical trainees with the number of advanced surgical training positions expected to exist when they finish – is to ensure a smooth transition for basic surgical trainees to advanced surgical training.

Selection of trainees for advanced surgical training

Selection process

6.42 Appointments to the advanced surgical training program are made either through a national selection committee or a regional sub-committee of the relevant Specialty Board (or affiliated surgical association) of the College. The Commission understands that all surgical sub-specialties were to have a national selection process in place by 2002. The selection committee varies with each Board, but the College has advised that ideally there should be representatives from the College and the relevant training hospital, usually the hospital medical superintendent.

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[80] Applications for advanced surgical training may also be received from registered advanced surgical trainees from another specialty, from overseas trained doctors who have been assessed as having equivalence to the basic surgical training program, or from existing fellows wishing to pursue a different speciality.

6.43 The same selection tools are used in the selection of trainees across the nine surgical sub-specialties, namely:

- structured curriculum vitae;
- referee reports; and
- semi-structured interview.

6.44 Pre-determined components of each of the above selection tools are scored and tallied. The Commission understands that each sub-speciality assigns its own weighting to these components. A nationally ranked list of applicants is prepared in each area of surgery. A case study demonstrating the selection processes adopted by the Australian Orthopaedic Association is provided below.

6.45 Offers in each sub-speciality are then made to applicants in order of merit until either:

- the pre-determined minimum standard for qualified candidates is reached; or
- all available posts are filled.

6.46 Trainees who are unsuccessful in obtaining a position in their preferred advanced surgical training program are advised in writing that feedback and counselling is available. The Commission understands that there is some variation across the sub-specialities as to how this is done, some as face to face interviews others by phone.

6.47 An overview for the 2001 advanced surgical training application process for general surgery is provided in Table 6.1 below.

Table 6.1: Overview of the advanced general surgical application process for 2001	
Closing date for applications.	28 May 2001
Acknowledged receipt of application letters.	By 1 June 2001
Referee reports sought.	By 8 June 2001
Referee reports due back.	29 June 2001
Referee reports not received sought.	By 13 July 2001
Part 1 Basic Training Examination results available.	6 July 2001
Eligible applicant details distributed to States for interviews to be arranged.	By 11 July 2001
Ineligible applicants notified.	By 11 July 2001
Interviews to be held.	Week of 20 August 2001

Final date for interviews.	24 August 2001
Board Selection Meeting/Teleconference.	Week of 27 August 2001
First round offers made.	Week of 3 September 2001
Acceptance of positions to be returned.	21 September 2001

Semi-structured interview

6.48 As with the selection of basic surgical trainees, an interview pro-forma is followed for each applicant for advanced surgical training. The interview generally consists of six questions which relate to the following attributes:

- the ability to interact effectively and affably with peers, mentors, members of the health care team, patients and their families;
- the ability to contribute as a member of a health care team;
- the ability to act ethically, responsibly and with honesty;
- the ability to perform realistic self-assessment;
- a capacity for caring, concern and sensitivity to the needs of others; and
- effective spoken communication.

6.49 The process for scoring and reaching consensus on the trainee's performance at the interview is the same as that for the selection of trainees for basic surgical training. The interview panel is issued with criterion statements (see Table 6.2 below) which are used as a guide in judging a candidate's response for each attribute.

Table 6.2: Selection criteria for the advanced surgical training interview [81]

Attribute (advanced surgical training)	**Criterion statement**
The ability to interact effectively and affably with peers, mentors, members of the health care team, patients and their families.	A suitable candidate will be aware of the need to communicate at the level, and in a manner appropriate to the setting and circumstances of the interaction, and in particular recognise the need for affability and avoidance of arrogance, judgemental or patronising behaviour.
The ability to contribute effectively as a member of a health team.	A suitable candidate will demonstrate the potential to work well in a team by describing a positive attitude to

[81] College submission to the Australian Medical Council, May 2001, Attachment 26.

Table 6.2: Selection criteria for the advanced surgical training interview [81]	
Attribute (advanced surgical training)	**Criterion statement**
	collaboration which recognises the roles and needs of other team members, shows appropriate leadership skills and acknowledges the effect of his/her own attitude and behaviour on team morale and effectiveness.
The ability to act ethically, responsibly and with honesty.	A suitable candidate will be sensitive to, and recognise the ethical dimensions of day to day professional activities, be aware of and apply appropriate ethical and moral principles and act responsibly and with honesty when making professional decisions.
The ability to perform realistic self-assessment.	A suitable candidate will show insight into his/her own performance (decision making as well as technical skills) by demonstrating a willingness to systematically seek out, and be receptive to, evaluative feedback from all appropriate sources, while recognising and acknowledging the limits of his/her own knowledge and skills by acting appropriately to improve them.
A capacity for caring, concern and sensitivity to the needs of others.	A suitable candidate will demonstrate a capacity for empathy by acknowledging and showing concern and understanding for the thoughts and feelings of others, and by providing emotional support and practical advice to encourage autonomy and self-respect.
Effective spoken communication	A suitable candidate will demonstrate in the interview setting basic listening and speaking skills commensurate with the need to communicate succinctly, fluently and effectively in clinical and professional settings.

Case study – selection of trainees for advanced orthopaedic surgical training program 2002 by Australian Orthopaedic Association[82]

The purpose of the case study is to provide an example of how the selection process for advanced surgical trainees operates in practice. The case study details the selection process for entry into the advanced orthopaedic training in Queensland in 2002.

Selection into the 2002 Queensland advanced orthopaedic training program was based on an assessment of:

1. an applicant's curriculum vitae;
2. referee reports;
3. discussions with people for whom an applicant was working in relation to surgical skills, knowledge, ability to present cases, decision making ability, patient communication, patient management, teaching skills, interaction with other medical staff, reliability, diligence, honesty, insight and ability to follow instructions; and
4. performance at structured interviews of 10 minutes each covering ethics and principles, undergraduate and post graduate training, clinical situations and practical skills.

The Commission notes that this process appears to be different to the process described in the College's application. In particular, it includes discussions with people for whom the applicant is working. The interview component also appears to be structured differently.

Curriculum vitae and referee reports

Assessment was carried out by a training committee consisting of 13 members. For the 2002 training program, 14 applications for advanced orthopaedic training program in Queensland were received. Applications were ranked in order by each training committee member. The rankings were averaged and a score then assigned to each application. For the 2002 training year, the applicants receiving the top seven scores were accepted into advanced training in Queensland.

With regard to referee reports, three questions were asked of referees. The first question requested a level of recommendation and grades the answers 1-5. The second question asks for the referees to state their preparedness to work with the applicant, with there being 4 levels of reply possible. The third question requires an overall rating of the applicant's clinical qualities with 4 grades of reply possible. The top seven successful applicants for the 2002 training program achieved between 1 and 2.5 demerit points in this section.

Interview

The interview session is comprised of 4 different interviews with a different interviewer at each station. The interviews explore ethics and principles, training and research, clinical situations and practical skills. The scoring system used was:

[82]This case study was sourced from a letter from the Queensland Branch Training Committee of the Australian Orthopaedic Association provided to the Commission during the course of considering the application for authorisation.

Very poor
Poor
Reasonable
Good/average
Very good
Outstanding
Excellent
Based on the applicant's curriculum vitae, referees reports and interview performance, each applicant was ranked and the top seven candidates accepted into advanced orthopaedic surgical training. Verbal feedback is also provided on applicant's work performance; however, these comments are not crucial in the assessment.

Training advanced surgical trainees

6.50 Advanced surgical training extends over four or more years, depending on the sub-speciality concerned, and involves the application of surgical sciences appropriate to the sub-speciality as well as to the practice of surgery. As with basic surgical training, advanced training programs generally operate in a similar manner to an apprenticeship system. Advanced trainees work in accredited training positions under the supervision of College Fellows, and acquire exposure to, and experience in, a range of diagnostic and treatment procedures as outlined in the relevant syllabus. The Commission is advised that each Fellow would supervise on average one to two trainees at a particular institution. Each trainee could be under the supervision and teaching of between three to six consultants, and would average seven sessions per week of contact with their consultant. The trainee also accepts escalating responsibility in operative surgery and undertakes more complex operative procedures as the program progresses.

6.51 Training is hospital based. During advanced training, a trainee occupies a structured cycle of College accredited hospital posts of six months duration. The Commission understands that advanced trainees generally rotate through a series of different hospitals during training, at least one of these being a non-metropolitan post.[83] The trainee's hospital rotations are closely monitored by supervisors to ensure that sufficient and competent experience is obtained in specified surgical procedures.

6.52 Trainees are provided with a Guide to Surgical Training which contains the syllabus for their chosen surgical specialty. The Commission understands that the level of detail of the syllabus varies with each specialty. For example, the Board of Neurosurgery provides a syllabus to trainees which, amongst other things, lists the core tutorial topics and provides an extensive recommended reading list. Some specify the main academic areas on which trainees need to focus in conjunction with the 'hands on' training program provided in the hospital environment, as well as the area and number of surgical procedures that need to be undertaken by the advanced trainee. However, this is a guide only. The Commission understands that other specialties provide trainees with a more detailed syllabus.

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[83]College submission to the Australian Medical Council for Accreditation, May 2001, p21.

6.53 The Commission understands that advanced trainees are also required to attend a range of after hours educational activities. These vary between hospitals and from state to state, but would generally include the following activities:

- specific topic meetings where each trainee would prepare a presentation on a certain topic presenting this to the assembled group and be prepared to answer questions and participate in further discussion;
- case presentations;
- presentation of selected journal articles to keep up to date with the current literature in an open forum and to specifically explore the trainee's knowledge and effort to read around these topics;
- trial examination sessions, particularly for later year trainees to improve their exam technique and test and improve their knowledge base;
- teaching ward rounds; and
- consultant presentations where specific topics are presented in a mini lecture format to facilitate discussion. The College advises that in order to deal fairly and appropriately with each trainee and with each topic, full participation cannot be open to everybody. People interested in surgical training may attend these sessions as part of an educative experience, but the timeframe would not allow them to participate as a full member of the group, without detriment to the time allocated to trainees occupying accredited posts.

6.54 In addition, advanced surgical trainees are required to complete an investigative project which may be in the form of a presentation of a paper, a publication in a journal, a dissertation with a written review of a clinical problem, a period of full time research, or a higher degree. The project is certified by the Regional Sub-Committee to the relevant Specialty Board prior to the trainee sitting the Part 2 (Fellowship) Examination.

6.55 Advanced trainees may also undertake part-time or interrupted training after a full year of the advanced training program has been completed in a full-time capacity.

6.56 Advanced surgical training is overseen by the Censor-in-Chief, who chairs the Board of Advanced Surgical Training. Each of the Speciality Surgical Boards are represented on this Board. For some surgical specialties, the College has delegated responsibility for training activities to various speciality associations.

6.57 The training requirements for each of the College's surgical areas are briefly outlined below.[84]

General surgery

6.58 The General Surgical Board of the College oversees the general surgery program. The period of training is five or six years. The first three years cover a broad range of

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[84]The College's submission in support of the application, 30 March 2001 and the College's submission to the Commission, 3 June 2003, Attachment 2.

surgical procedures, while the remaining two or three years focus on one sub-specialty. During the first three years trainees are required to gain a minimum operative experience of 600 major cases. Training in general surgery overlaps with the other specialities.

Cardiothoracic surgery

6.59 The Cardiothoracic Surgical Board of the College oversees this program. The period of training is six years. Cardiothoracic trainees must spend two years in advanced training in general surgery and four years in advanced training in approved cardiothoracic surgery posts performing open-heart surgery for acquired and congenital heart disease. For trainees who already hold a Fellowship in general surgery, the advanced training program in cardiothoracic surgery will comprise four years in cardiothoracic surgery.

Neurosurgery

6.60 The Neurosurgery Board of the College and the Neurosurgical Society of Australasia oversee the advanced training program for Neurosurgery. Neurosurgery training extends over a five-year period, with four years in approved accredited posts and one year being a research/elective year. Rotation between units is expected with no more than two years of training approved in one unit, except for exceptional circumstances. The training program incorporates the management of head injuries and other injuries of the nervous system.

Orthopaedic surgery

6.61 The Orthopaedic Board of the College and the Australian Orthopaedic Association oversee this program. Training in orthopaedic surgery is conducted over a minimum of four years, with the option of spending one of those years in an approved medical, general surgical or research post. During the three years in approved posts, trainees are required to undertake two years in elective orthopaedics and twelve months in traumatic orthopaedics. Rotation between units is expected with no more than two years of training approved in one unit, except in exceptional circumstances. Trainees are required to sit for an orthopaedic principles and basic sciences exam during their first year, which is unique to the sub-specialty.

Otolaryngology - head and neck surgery

6.62 The Otolaryngology – Head and Neck Surgery training program is overseen by the Board of Otolaryngology – Head and Neck Surgery of the College and the Australian Society of Otolaryngology – Head and Neck Surgery. Training is conducted over a four year period, and trainees are expected to become familiar with all aspects of medicine and surgery involving the main subdivisions of the sub-speciality, namely otology, rhinology, larynology and head and neck surgery. Trainees are required to rotate through a combination of a minimum of three hospital posts and should remain no longer than one year in any one approved hospital training post. Experience in paediatric otolaryngology is essential.

Paediatric surgery

6.63 The Paediatric Board of the College and the Australasian Association of Paediatric Surgeons oversee the advanced surgical training program. Training extends for six

years, consisting of three years in the general surgical training program and a further three years in an approved paediatric surgical training program including the completion of the advanced paediatric life support course. Alternatively it consists of five years of general surgery in the approved hospital training program to obtain a Fellowship in General Surgery followed by three years in clinical training in approved paediatric surgical positions.

Plastic and reconstructive surgery

6.64 The Plastic and Reconstructive Surgery Specialty Board of the College oversee this program. Plastic and reconstructive surgery requires five years of training consisting of one year in the general surgical training program and a further four years in the plastic and reconstructive surgical training program. With the prior approval of the Board, a maximum of twelve months research may be accredited as approved training during any year of advanced surgical training.

Urology

6.65 The Board of Urology of the College and the Urological Society of Australasia oversee the advanced training program. It is a four year training program. The first three years are spent in different training units to allow a broad range of experience. The fourth year requires a program to be submitted in advance to the Board and may include a period of work in a subspecialty of urology, in research or in an interstate or overseas training post. Specific guidelines apply to these posts.

Vascular surgery

6.66 The Vascular Surgical Board of the College oversees this program. Vascular surgery requires five years of training involving two years in the general surgical training program and three years in the vascular surgery training program.

Assessment of advanced surgical trainees

6.67 Assessment of advanced surgical trainees consists of three primary elements, namely:

- the maintenance of log books by the trainee;
- the completion of in-training assessment reports by the surgical supervisor; and
- the Part 2 Examination.

Logbooks

6.68 Logbooks are the medium through which the Specialty Boards (or affiliated surgical associations where relevant) review the progress of trainees, and particularly the minimum number of procedures that need to be completed by each advanced trainee. In this regard, all specialties require trainees to complete a logbook setting out the number and range of operations they have completed. More specifically, logbooks also provide information on:

- operation statistics and outcome of surgery; and
- educational activities, such as research, publications, presentations at meetings and attendance at courses.

6.69 The logbooks are reviewed every six months by training supervisors. They are also used by accreditation inspection teams to assess the worth of the individual training post.

In-training assessment reports

6.70 Surgical supervisors are required to complete an in-training assessment report on advanced trainees at the conclusion of each six month term. Reports are read and signed by the trainee. An interview with the trainees is also required and a mid-term review of performance is recommended. This assessment relates to the trainee's overall performance and takes into account various factors including:

- attitude;
- clinical skills;
- technical skills;
- teaching/continuing medical education;
- research; and
- logbook statistics.

6.71 If a trainee's performance is deemed unsatisfactory, the term in question will not be credited towards the trainee's program. Deficiencies in performance are identified by their supervisor and discussed with the trainee, and strategies for improvement are suggested. Continuing poor performance may result in dismissal from the program. Greater detail in relation to procedures for dismissal from the Advanced Surgical Training program is provided below.

Part 2 (Fellowship) Examination

6.72 Trainees have to apply to the Censor-in-Chief for permission to sit for the Part 2 Examination. The examination is normally undertaken in the final year of advanced training. In making this decision, the Censor-in-Chief may take into account:

- recommendations of the relevant Specialty Board concerning satisfactory length and scope of training;
- confidential reports from supervisors of training;
- referee reports; and
- information from logbooks.

6.73 Each surgical sub-specialty has a different examination, covering the requirements laid down in each syllabus. Generally, the examination has six segments:

- written Papers I and II;

- a clinical examination of a 'long' case. This exercise is approximately 40 minutes in duration and is conducted in a clinical setting with a high level of complexity;
- a half hour oral examination on operative surgery;
- a half hour oral examination on surgical pathology; and
- a half hour oral examination on surgical anatomy, with specimens.

6.74 Advanced trainees may re-sit the examination should they be unsuccessful, and there is no formal limit on the number of times a trainee may sit the Part 2 Examination. However, the Censor-in-Chief must approve eligibility to sit the exam each time. The pass rate for the Part 2 Fellowship Examination from 1995 to 2000 is detailed in paragraph 6.156 and Table 6.5 below.

Dismissal from the advanced surgical training program

6.75 An advanced surgical trainee may be dismissed from the program for repeated unsatisfactory performance, as identified in the in-training assessment reports.

6.76 At any time during training, a trainee may receive a written warning which details specific deficiencies in his or her performance and specifies the goals to be achieved in remedying the deficiencies in a suitable time frame. A trainee may also be informed that they are underperforming at the time of his or her six-monthly assessment report.

6.77 Generally, a trainee is given a minimum of two written warnings before dismissal is considered. However, in the event of serious misconduct, dismissal may occur at any time. In the event that a trainee receives two written warnings, the Hospital Supervisor for Surgical Training (responsible for coordinating the basic surgical training program, for advising trainees and ensuring the completion of their in-training assessment reports) provides a written report to the Regional Sub-Committee of the relevant Specialty Board. The trainee is provided with two weeks notice of a meeting with the Regional Sub-Committee, where the trainee is invited to prepare a submission in relation to the documented deficiencies. A record of the meeting is kept, including the Committee's recommendation about whether to dismiss the trainee from the advanced training program. The onus is on the Regional Sub-Committee to substantiate its decision to the Specialty Board, which makes its decision based on the recommendation of the Committee. Before the decision is ratified, the Censor in Chief must be satisfied that due process has been followed and be provided with documentary evidence of warnings and minutes of any meetings discussing a trainee's performance.[85]

[85]College submission to the Australian Medical Council for Accreditation, May 2001, (Attachment 37), *Guidelines for Surgical Boards in Dismissing Advanced Surgical Trainees from the Training Program.*

Training costs[86]

Basic surgical training

6.78 In 2003, the total course cost to trainees of the basic surgical training program in year 1 is $8185 and $9485 in year 2. These fees are paid to the College. The fees consist of:

- registration fee (year 1) of $1275;
- annual training fee of $2185;
- distance learning program (year 1) $1845;
- basic surgical skills course (year 1) $1440;
- Early Management of Severe Trauma course (year 1) $1440;
- Care of the Critically Ill Surgical Patients course (year 2) $1440;
- Multiple Choice Examination (year 2) $3535; and
- Objective Structured Clinical Exam (year 2) $2325.

Advanced surgical training

6.79 The total course cost to trainees of the advanced surgical program varies depending on the surgical sub-speciality and the length of training. Fees are paid to the College. Common costs include:

- registration fee (year 1) of $1275;
- annual training fee $2185; and
- Part 2 Examination entry fees of $4680.

Total fees

6.80 Total fees vary between sub-specialties, given the different lengths of sub-specialty training programs. For example, the total fee for orthopaedic trainees is around $33,000 (six years in total), while the total fee for cardio-thoracic and paediatric trainees is around $37,000 in total (eight years in total).

Fellowship fees

6.81 The 2003 annual subscription fee to the College (payable on 1 January 2003) was $1600. The Fellowship entrance fee is $5200 (payable in full for a 10 per cent discount or over five years).

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[86]Figures sourced from the College website at www.racs.edu.au/news, *Summary Of Subscriptions For 2003 and Examination, Training and Other Fees for 2002 & 2003.*

Granting of College Fellowship

6.82 For advanced surgical trainees who pass the Part 2 Examination and who have completed training, a recommendation for admission as Fellow is made to the Council of the College by the Censor-in-Chief, on the advice of the relevant Surgical Board. If Council approves the recommendation, the Diploma of Fellowship (FRACS) is awarded.

6.83 The College retains the discretion to withhold granting of Fellowship to trainees who have successfully completed advanced surgical training, although it submits this discretion has never been exercised.[87]

Accreditation of hospitals and hospital training posts

6.84 The aim of the College's accreditation process is to ensure trainees receive the quality of training necessary to produce safe and competent surgeons. With respect to basic surgical training, the College accredits the hospital itself. However, for advanced surgical training, each advanced surgical post within the hospital must be accredited.

Accrediting hospitals to provide basic surgical training

Accreditation criteria

6.85 The accreditation criteria that must be met by hospitals wishing to provide basic surgical training are:

- that the hospital has a Basic Surgical Training Supervisor appointed by the Board of Basic Surgical Training;
- that the Basic Surgical Supervisor is provided with adequate support (secretarial, office);
- that there is a library;
- that there are internet facilities enabling access by basic surgical trainees to the College's basic training website;
- that the hospital has appropriate processes for clinical audit and for review of morbidity and mortality;
- that there is a simple facility for all basic surgical trainees to practise basic surgical skills (a room, cupboard, desktop with basic equipment);
- that there is commitment from surgeons of the hospital to support the basic surgical training skills courses and the basic training examinations;
- that basic surgical trainees are involved in using and developing basic surgical skills and their progress is monitored;

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[87]College submission to the Commission, May 2001, p3.

- that there are opportunities for basic surgical trainees to be involved in acute patient resuscitation;
- that surgeons are involved in mentoring basic surgical trainees;
- that basic surgical trainee rotations undergo review with input from trainees;
- that clinical rosters are appropriate; and
- that study leave is provided for designated College basic surgical courses.

Accreditation process

6.86 The College requires a hospital to provide it with extensive documentation, followed by an inspection of the hospital by representatives of the College.

6.87 Surgeons are appointed for one calendar year at a time to perform hospital site visits for a particular region. Surgeons may be re-appointed on an annual basis. Inspections are completed and reported to the relevant Regional Sub-Committee of the Board of Basic Surgical Training.

6.88 A hospital inspection occurs on a day arranged with the hospital. In assessing the hospital against the above listed criteria, the basic surgical training inspectors interview the:

- Basic Surgical Training Supervisor;
- trainees at the hospital;
- Director of Medical Services; and
- Director of Clinical Training.

6.89 Based upon the joint recommendations of the Director of Medical Services and the Director of Clinical Training regarding the possible number of basic surgical training posts at the hospital, the inspectors make a recommendation to the Regional Sub-Committee regarding the maximum number of posts available for basic surgical trainees at each hospital. This recommendation takes into account whether basic surgical trainees in the first year of the program will be able to move into subsequent basic surgical posts within the same hospital in the second year of the program.

6.90 In addition, the inspectors make an assessment regarding the possible number of training posts available for trainees in years three or four of the basic surgical program. Inspectors may interview supervisors of advanced surgical training to assess these numbers. Trainees occupying such posts include trainees who have not sat the Part 1 Multiple Choice Exam, who have sat but not yet passed the multiple choice exam, or who have passed the entire Part 1 Basic Training Examination but have not yet been accepted into advanced surgical training. Trainees in these positions are expected to have registrar level responsibilities. They will include posts formerly referred to as 'non-accredited' registrar positions. Registered basic surgical trainees

occupying such posts are now referred to as 'basic surgical training registrars', which reflects both their employment designation and their College training designation.

6.91 The number of hospitals accredited for basic surgical training during 2001 is discussed below at paragraph 6.157.

6.92 Rural hospitals involved with trainee rotations are assessed separately for their suitability for basic surgical training according to the above listed criteria.

Hospitals in rural and regional areas

6.93 The following reports are provided by hospital inspectors to the Regional Basic Surgical Training Committee and the Board of Basic Surgical Training:

- a report on the extent to which each hospital in the region meets the assessment criteria;
- a general report on basic surgical training in the region which has been assessed, with an assessment of the number of posts from year one to four of basic surgical training which can be supported within the region. Particular clarity is required with respect to year one and year two of basic surgical training. The report should also include an indication of the reasonable number of positions available for entry into year one of basic surgical training and the probable maximum number which could be reached if expansion of these numbers were required in the future; and
- a more general report reflecting the implementation of basic surgical training measured against the available basic surgical training regulations and guidelines. The report should include aspects of the functioning of the basic surgical training program in the region which should be addressed by the Regional Basic Surgical Training Committee. The report may also include reference to aspects of the basic surgical training curriculum objectives which should be referred to the Board of Basic Surgical Training for consideration.

Accrediting advanced surgical training posts

Accreditation criteria

6.94 Training posts are accredited according to criteria specified by the Board of Surgical Training responsible for the post. However, there are some common criteria each advanced surgical training post must satisfy, namely:

- provision of clinical experience to ensure the development of diagnostic, therapeutic and operative skills:
  - in the operative room
  - in peri-operative care;
  - in the emergency room, including trauma; and
  - in the ambulatory or outpatient setting;

- access to teaching and educational workplace programs to ensure acquisition of knowledge and the development of a life long education strategy:
  - regular clinical and educational meetings within the hospital or related institutions, relevant to the stage of surgical training;
  - availability of educational resources including a medical library and information technology;
  - support and encouragement for self-directed learning;
  - opportunities for critical appraisal of the medical literature; and
  - opportunities for teaching students and junior staff; and
- access to peer review and surgical audit to promote accountability, safety, quality assurance, error recognition and correction and clinical standards setting, including but not restricted to:
  - regular peer review meetings; and
  - maintenance and review of clinical experience.

6.95 The Commission understands that in addition to the above criteria, each surgical sub-specialty requires specific services or facilities appropriate to that sub-specialty. For example, the ideal requirements for a plastic surgery unit include:

- there should be an adequate number of consultants all of whom should be involved in post graduate activities;
- there should be a minimum of 14 beds, and a suitable examination and dressing room adjacent to the ward;
- operating facilities should form part of a major operating suite;
- the clinic should have access to other clinics such as audiology, dermatology, orthopaedics, dental and orthodontics;
- medical records and secretarial help is essential;
- the unit should engage in a substantial range of plastic surgery work from among the following categories: paediatric, facial, head and neck, burns, general (skin cancer, lymphoedema) and aesthetic;
- regular journal meetings with supervisors and trial exams may be of value to an advanced surgical trainee;
- there should be adequate time for research and presentation of papers;
- units should have access to a computer for data storage and analysis of information in plastic surgery;
- the unit should have access to comprehensive photographic and art facilities;

- a nurse training program in plastic surgery is a desirable addition to a unit;
- access to a prosthetics laboratory is valuable; and
- all approved units must be inspected every five years.

6.96 In addition to meeting specific surgical training criteria, to obtain accreditation each individual hospital should also provide the following:

- a range of surgical supervisors;
- appropriate case load and case mix;
- a balanced hospital service, preferably with recognition by the Royal Australasian College of Physicians for training in internal medicine;
- anaesthetic staff with approved higher qualifications recognised by the Australian and New Zealand College of Anaesthetists;
- intensive care staff with approved qualifications from the Joint Faculty of Intensive Care;
- a laboratory service including adequate clinical pathology morbid anatomy, microbiology and biochemistry;
- access to an appropriate number of autopsies;
- access to appropriate information technology equipment;
- recognition of the Australian Medical Association (AMA) Safe Hours policy;
- an adequate diagnostic radiology department;
- an emergency accident service with 24 hours resident medical officer cover;
- outpatient clinics providing a comprehensive consultative service (although full accreditation may still be granted without an outpatient clinic);
- an effective system of hospital records;
- an adequate establishment of resident medical officers;
- a surgical education committee or its equivalent;
- appropriate variety of clinical material for training;
- adequate personal operative experience for the trainee under the supervision of surgeons possessing higher surgical qualifications recognised by the College;
- each training period must provide a reasonable period of continuity (normally at least six months for Advanced Surgical Training);

- structured teaching program for Advanced Surgical Trainees;
- additional training facilities should include a medical reference library, regular formal clinical meetings and conferences and the opportunity to attend surgical education meetings; and
- a surgical audit system.

The accreditation process

6.97 There are two stages of the accreditation process. First, the College requires a hospital to provide it with extensive documentation, including information on hospital facilities, case numbers and educational opportunities for all trainees, which is then followed by an inspection of the hospital by representatives of the College.

6.98 In relation to all advanced surgical posts, the College adopts the following accreditation procedures:

- On advice of the relevant Surgical Board, the Censor in Chief (who chairs the Board of Advanced Surgical Training, and reports to the Education Policy Board) will appoint an inspection team, which comprises a minimum of two representatives of the Surgical Board who are not involved with the applicant hospital. The Commission understands it is possible to appoint interstate or New Zealand surgeons to this team if necessary.
- The College will liaise with the hospital administration, the Hospital Supervisor of Surgical Training, the Speciality Supervisor and the inspection team to arrange a suitable time for the inspection.
- The inspection team interviews the Hospital Supervisor of Surgical Training, the Speciality Supervisor and each advanced surgical trainee in the program when conducting a review of an existing accredited post. The inspection team will then inspect the unit and related facilities. The team normally reviews the logbook of each advanced trainee in each program. At the conclusion of the visit, the team holds a discussion with the Supervisors and the administrative staff to obtain further information prior to compiling the inspection report.
- The inspection team presents the final report to the hospital for a response prior to final deliberations of Council on the report.

6.99 In addition, the Commission understands that inspection reports note whether funding (for example salaries) is secured for the post and may comment on the teaching skills of the surgeons on staff. They also record certain hospital statistics including the number of surgical beds and population served, and statistics of the relevant surgical unit including annual separations, weekly operating sessions, whether there are dedicated ward and nursing staff.

6.100 Furthermore, the Commission understands that accreditation reports provide scope for inspectors to record the strengths and weaknesses identified in relation to a particular advanced surgical post. For example, a trainee's exposure to research activities and certain surgical procedures to ensure there is enough clinical material may be noted.

6.101 However, the report may list specific issues, which if rectified at the time of review, would ensure accredited status. Limited accreditation of hospital training posts is discussed in further detail below.

Monitoring and review of accredited posts

6.102 Each of the surgical sub-specialities of the College annually monitors whether training posts and hospitals continue to meet accreditation requirements. The Commission understands that this is done primarily through the trainee logbooks, which provide information on the number and type of operations that the trainee has undertaken and the level of supervision of the trainee.[88]

6.103 Accreditation is reviewed by College Fellows at the request of hospitals or according to the College's rolling schedule of hospital inspections. The process followed by the College in reviewing an accredited post is essentially the same as that previously described above at paragraphs 6.96 – 6.100.

6.104 In carrying out this monitoring role, the College may disaccredit a hospital training post on the basis of their being a material change in circumstances where required standards are no longer being met.

Duration of accreditation

6.105 The duration of a hospital post accreditation is normally five years for a principal teaching hospital, where the bulk of training programs are located, and one year for an affiliated hospital.

6.106 However, it appears possible to accredit posts for a more limited period. In particular, if hospitals or posts do not meet all criteria, yet are able to satisfy the main components and are granted limited accreditation, usually for a period of one year, subject to rectifying the outstanding criteria in three, six or twelve months time. Limited accreditation is granted only where the outstanding criteria are relatively minor and would not have a detrimental impact on the overall training program.

6.107 Further detail regarding the number of hospital posts accredited for advanced surgical training, is provided at paragraphs 6.158-6.163.

Assessment of overseas trained practitioners

6.108 Applications from overseas-trained practitioners for specialist recognition in Australia are referred to the College mainly from the Australian Medical Council (AMC). In 2000, the College received 80 applications for assessment from overseas-trained practitioners. The College also receives a very small number of applications directly from overseas-trained practitioners where the applicant has an AMC Certificate.

6.109 The purpose of this assessment procedure, as developed by the AMC and the College, is to assess the equivalence of training and qualifications and experience of overseas-trained practitioners with Australian-trained practitioners.

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[88]College submission to the Australian Medical Council for Accreditation, May 2001, p17.

Assessment criteria

6.110 The application process and guidelines used by the College for assessment are the same for all applicants regardless of the proposed position the applicant wishes to hold. The role of the College is to assess the qualifications, training and experience of an overseas-trained surgeon to determine what further requirements, if any, must be met to be assessed as equivalent to an Australian-trained surgeon in the relevant surgical sub-specialty.[89] For example, an overseas-trained practitioner with 20 years' experience will be compared against an Australian-trained practitioner with the same amount of experience. The Commission understands that the practitioner's experience is primarily assessed via an examination of his or her logbooks.

6.111 For an overseas-trained surgeon whose specialisation is narrower than the surgical specialities in Australia the College advised the Commission that it would assess the equivalence of the overseas-trained surgeon against an Australian-trained surgeon with a similar number of years experience in the same narrow field of surgery. The College recommendation would identify that the surgeon had been assessed as equivalent to an Australian-trained surgeon in the narrow field only. [90]

Assessment process

6.112 The College receives applications from the AMC on behalf of overseas-trained surgeons throughout the calendar year. The College generally follows the assessment procedures specified in the AMC/Committee of Presidents of Medical Colleges *Assessment of Overseas Trained Specialists: Template for Colleges*. Briefly, international applicants are required to supply the College with specific documentation in relation to their training and qualifications. The College does not begin assessment of an application until an applicant supplies all the necessary information.

6.113 The application is then forwarded to an assessment team at the College comprising the relevant Specialty Board Chairman and the Censor-in-Chief, and/or the Executive Director of Surgical Affairs. Following documentary evaluation, an interview with the applicant is normally scheduled to clarify the applicant's experience. The interview panel comprises the relevant Specialty Board Chairman, the Censor-in-Chief and/or his/her nominees. Nominees may include other Board Chairman or the College's Executive Director of Surgical Affairs.[91] The College determines what further requirements an applicant must meet, if any, and makes a recommendation in writing to the relevant referring agency.

6.114 A general overview of the assessment procedure for overseas-trained practitioners in Australia, including the role of the AMC and the relevant medical college is provided in Figure 6.1 below.

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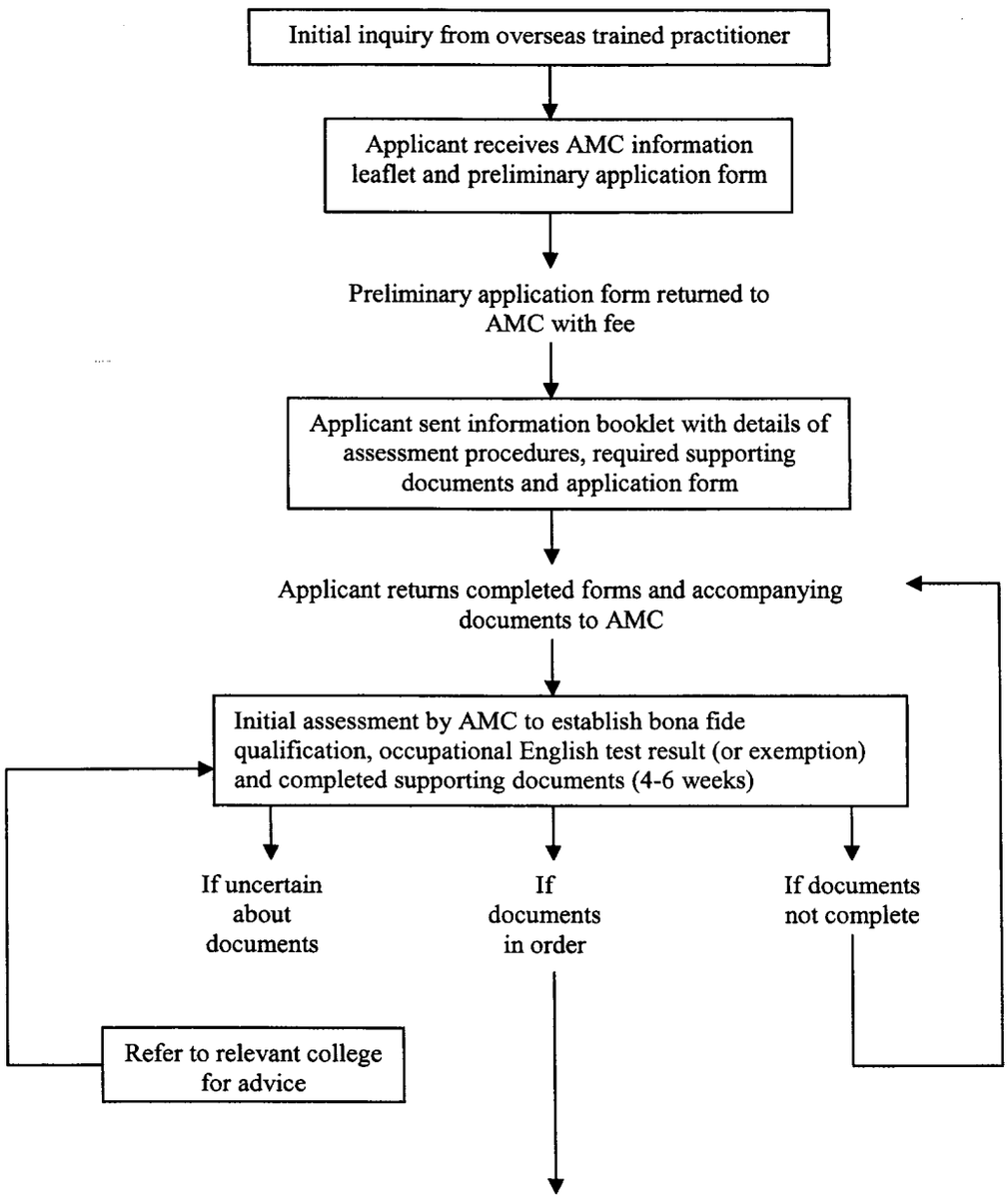
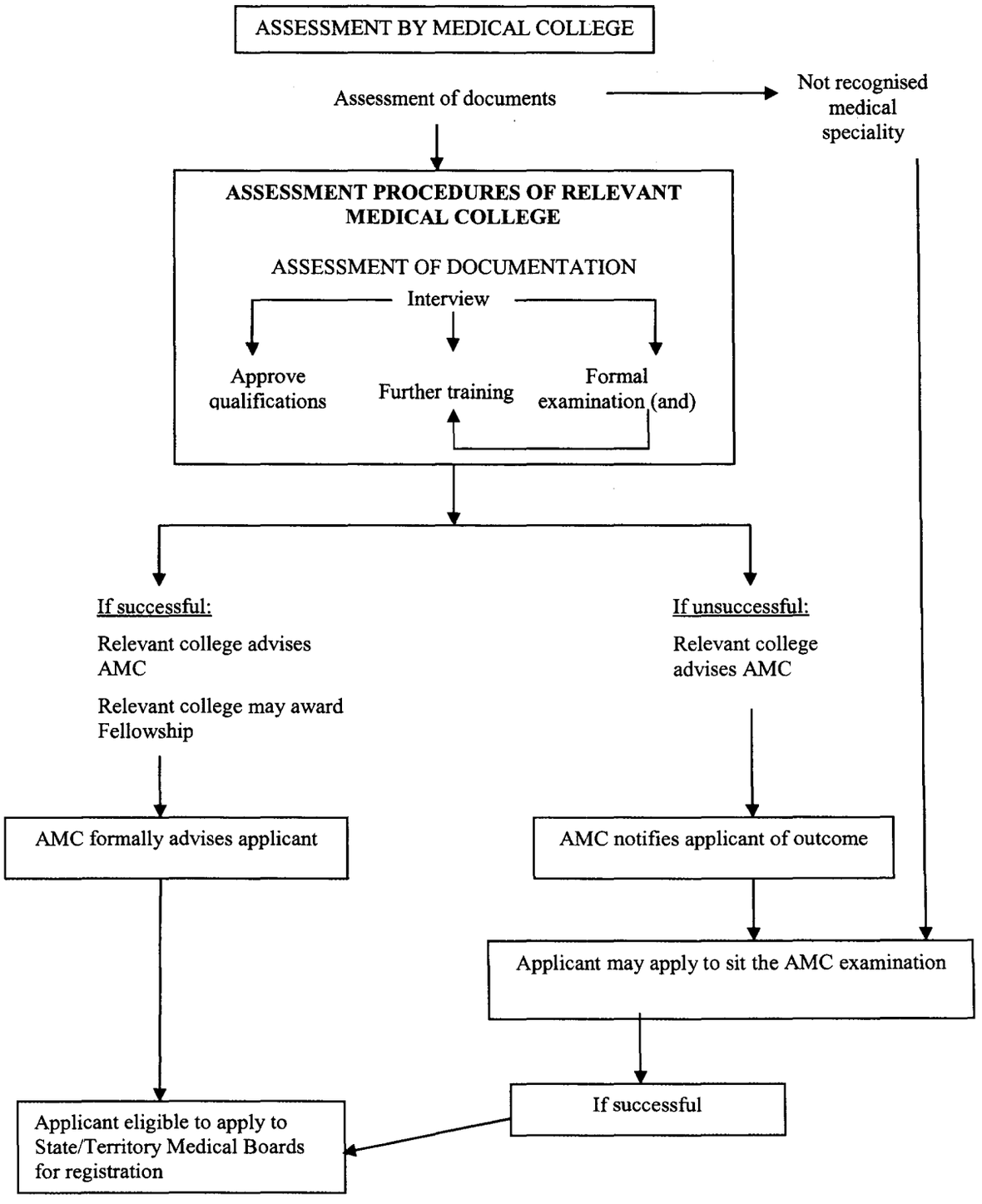
[89]Royal Australasian College of Surgeons supporting submission to the application for authorisation, 30 March 2001.
[90]Oral submission from the College, 3 April 2002.
[91]The College's submission to the Australian Medical Council for Accreditation, May 2001, p66.

Figure 6.1: Overview of the assessment process for overseas-trained practitioners[92]



[92] Australian Medical Council *AMC/Specialist Medical College Assessment Procedures Information 2001*, pp17-18.

Figure 6.1 continued



Documentary evidence

6.115 As previously mentioned, applicants are required to provide a range of documentation for assessment by the College, namely:

- a comprehensive curriculum vitae;
- full details of the applicant's training, including the basic sciences component, and the applicant's clinical surgical experience;
- details of each surgical post held by the applicant including in-training supervision and details of the supervising surgeons; the nature of the service provided; specific responsibilities and experience gained; evidence of in-training evaluations; and a copy of logbook statistics including a certified summary of those statistics;
- certified copies of undergraduate medical degree and any post graduate qualifications;
- an outline of any examinations undertaken including their nature. This involves providing details of the syllabus and results, including certificates;
- details of specialist practice including the location, nature and duration of specialist practice. Applicants must also provide the College with a letter from the privileges/credentialing committee of the hospital in which they practised and an audit for at least, their most recent year of specialist practice; and
- the names and current contact details of three referees. Nominated referees must include a senior colleague who has worked with the applicant within the last two years, a colleague who is located geographically in the same area as the applicant, and a colleague who practices in the applicant's specialty area.

6.116 The Commission understands that while the College is not bound by any time limit in carrying out its assessment process it does abide by the agreed process developed with other Colleges and the AMC (*Assessment of Overseas Trained Specialists: Template for Colleges*) that the assessment be completed within three months of the time when all the relevant materials have been received from the applicant.

Interview

6.117 Following documentary evaluation by the assessment team, an interview is normally scheduled. Further detail regarding the composition of an interview panel is given above at paragraph 6.112.

6.118 The purpose of the interview is to clarify any aspects of the applicant's surgical practice and training that are not immediately evident in their documentation. In addition, the following attributes are assessed during the interview:

- the ability to act ethically, responsibly and with honesty;
- the ability to perform realistic self assessment;
- the ability to contribute effectively as a member of a health care team; and

- effective spoken and written communication.

6.119 The overseas-trained doctor's knowledge of the Australasian health care system is also assessed during the interview. The Commission understands the interview runs for approximately 50 minutes, and is conducted in accordance with an interview pro-forma developed by the College. It consists of a mixture of standard questions and hypothetical scenario questions.

6.120 The overseas-trained practitioner's responses are rated against a criterion statement linked to each of the above listed attributes. The ratings range from an excellent response to a non-suitable response (1-5). The criterion statements are similar to those listed previously at Table 6.2.

6.121 Further detail regarding the assessment of overseas-trained practitioners, including the length of time taken to review an overseas-trained practitioner's qualifications and the countries where applicants completed the most recent training, is provided in paragraphs 6.164 – 6.167.

Recommendation

6.122 The recommendations arising from the interviews are determined by the profile of the individual applicants. The assessment team may recommend to the relevant referring agency that overseas applicants undertake further training and/or assessment before obtaining registration. In particular, applicants may be recommended to:[93]

- successfully complete basic surgical training, including the Part 1 Exam;
- successfully complete specific components of basic surgical training;
- if exempted from basic surgical training:
  - apply in open competition to successfully complete the entire advanced training program, including the Part 2 Examination, in the chosen specialty;
  - apply in open competition to enter the advanced training program in the chosen sub-specialty with the possibility of review following a specified minimum time. Following review, the applicant may be required to undertake further training or be granted permission to apply for and sit the Part 2 Examination in that sub-specialty;
  - undertake a specified period of on-site assessment of professional practice and, upon successful completion of all requirements during this assessment, successfully complete the Part 2 Examination; or
  - undertake a specific period of on-site assessment of professional practice and upon successful completion of all requirements during this assessment, apply for admission to Fellowship by election under the Articles of Association of the College (Article 21).

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[93] The College's submission in support of the application, March 2001, p35.

6.123 The aim of the period of on-site assessment is to allow surgeons to demonstrate and consolidate their clinical knowledge, skills and professional practice and to experience a period of acclimatisation to the local health care system under surgical supervision. If the surgeon is working in an Area of Need position (discussed below), oversight by a surgical supervisor may be provided at a distance.

6.124 During a period of on-site assessment, the College requires two nominated College Fellows to prepare progress reports on the overseas-trained practitioner. The overseas-trained surgeon is also expected to register in the College's 'Maintenance of Professional Standards' program requiring participation in continual medical education, surgical audit and peer review. Retrospective recognition of a period of assessment may be considered, provided that the requirements of audit, education and reporting are met.

6.125 Generally, an overseas-trained doctor will be recommended to sit the Part 2 Examination if they have recently been certified by the Board of the Accreditation Council for Graduate Medical Schools in the United States of America or have recently been issued a Certificate of Completion of Specialist Training in the United Kingdom. Overseas-trained doctors with years of surgical experience would generally be recommended for a period of assessment followed by an invitation to apply for election to Fellowship under Article 21 of the College's Memorandum and Articles of Association. [94]

Regulations for granting exemption from the Part 1 Assessment

6.126 Exemption from basic surgical training will be granted where the overseas-trained applicant holds particular qualifications. These qualifications currently are:

- the Applied Surgical Sciences and Principles of Surgery Package of the United Kingdom and Irish surgical colleges;
- the full Fellowship of the College of Medicine of South Africa; and
- holders of the MRCS/AFRCS Examination in the New British Surgical Training Schemes would normally be granted exemption from the Part 1 Examination. Individual Boards may specify further training and mentor assessments prior to the candidates being accepted for Advanced Surgical Training. [95]

Area of need assessment

6.127 The College also assesses the training, qualifications and experience of an overseas-trained practitioner for positions declared as an 'Area of Need' (AON) by state and territory health authorities. As discussed in Chapter 2, an AON refers to positions which are unable to be filled by local medical practitioners (see paragraph 2.29).

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[94] Article 21 also provides for an applicant to proceed directly to Fellowship without further training, examination or assessment. College submission, 13 March 2003, p 13.

[95] Source: The College's website at http://www.racs.edu.au/wedo/edu/index.html, *Regulations for Granting Exemption from the Part 1 Assessment.*

6.128 As of 1 June 2002, a new process to streamline the assessment and registration of overseas-trained specialists for AON positions was introduced. The new process was developed by the AMC and Committee of Presidents of Medical Colleges following a National Forum on AON practitioners held in Sydney on 1 December 2000. The Commission's understanding of the College's assessment procedures under the new system are outlined below.

6.129 Applications from overseas-trained practitioners for AON assessment are referred to the College from health service providers (for example the employing hospital). Before an AON application is referred to the College, a hospital identifies that a surgical position is required to be filled.

6.130 The Commission understands that whilst the employer has ultimate responsibility for the AON position description, the employer should liaise with the relevant Specialty Board of the College in developing key selection criteria to ensure that the skills and expertise required are appropriate to the field of specialist practice and the position to be filled. The position description should include such information as:[96]

- the position title;
- a comprehensive statement of duties;
- qualifications and experience – identifying and distinguishing between what selection criteria are regarded as 'essential' or 'desirable' and clarifying whether applicants must demonstrate either that they have practical experience or show that they have aptitude in a particular aspect of clinical practice;
- special requirements of the position which may be due to the geographic location or the specific nature of the medical services to be provided;
- clinical practice privileges or appointments relating to the position;
- any special conditions of employment; and
- the remuneration package of the position, including whether the applicant will be providing services that need to attract the Medicare rebates.

6.131 Once AON position description has been prepared, the hospital contacts the relevant State or Territory health authority to have the position declared as an AON position. If the position is approved, the hospital selects one suitable applicant who meets the position description and selection criteria. It is at this stage that the hospital refers the single application to the College, in the case of a surgical AON position, for assessment.

6.132 The College advised the Commission that the steps in the assessment process for area of need positions are the same as those carried out for other overseas-trained practitioners. However, the College focuses on assessing the competency of the

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[96] *Assessment Process for Area of Need Specialists Users Guide*, 2002 Edition, p3.

applicant to perform specific procedures outlined within the area of need position description.

Documentary assessment

6.133 Initially, the College receives a range of documentation from the employer's single preferred candidate in order to assess the suitability of the candidate for the AON position. At the same time, the employer refers the single application to the AMC to verify documentation.

6.134 To be a suitable candidate for the position, the College must consider that the applicant is 'close' to being comparable to an Australasian-trained surgeon in the same specialty area; requiring no more than two years in a designated period of assessment. If the candidate is deemed to require additional training as a means of attaining comparability to an Australasian-trained surgeon in the same specialty, they will not be recommended as a suitable candidate for the position.[97]

Interview

6.135 If the College remains undecided as to any aspect of the candidate's training, qualifications and/or experience, an interview is held with the relevant Speciality Board Chairman and the College Censor-in-Chief and/or his nominee(s).

6.136 Under the new process for AON assessment, within 8 weeks of receiving satisfactory documentation, the College is required to make its recommendation to the relevant state or territory medical board regarding the appropriate category of AON registration. At the same time, the College will define any limitations on the nature and extent of practice involved, and provide recommendations regarding requirements for ongoing assessment. The College also notifies the employing hospital and AMC in parallel with the medical board.[98]

Assessment of practice

6.137 The Commission understands that a designated period of assessment of clinical practice is mandatory for all AON applicants undergoing a College specialist assessment.[99]

6.138 The Commission understands that under the new AON process, the College will undertake ongoing assessment of the applicant after a defined period (initially 3 months and follow-up as required, and after 12 months).[100]

6.139 As is the case where a period of assessment is recommended for an overseas-trained practitioner seeking full recognition, the College requires that progress reports on the prospective AON practitioner be submitted by two nominated College Fellows, and that the practitioner register in the College's 'Maintenance of Professional Standards' program. The College forwards the progress reports to the relevant medical boards.

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[97] College submission to the Australian Medical Council for Accreditation, May 2001, p68.
[98] *Assessment Process for Area of Need Specialist, Users Guide, 2002 Edition,* pp15,16.
[99] College submission to the Australian Medical Council for Accreditation, May 2001, p68.
[100] *Assessment Process for Area of Need Specialist, Users Guide, 2002 Edition,* p26.

6.140 Should the applicant's practice be deemed unsatisfactory during the period of ongoing assessment the relevant state medical board may choose to withdraw or further limit the appointee's registration.

Fees for specialist assessment

6.141 An applicant for specialist recognition is required to pay a fee to the College. The Commission is advised that as at January 2002, there were three categories of fees. The College initially charges an applicant $4400 (Category 1 fee) for a documentary assessment and a face-to-face interview.

6.142 In addition, where an overseas-trained practitioner is required to undertake a period of on-site assessment, and the Fellows providing that oversight are located in the same workplace as the overseas-trained practitioner, the College charges $7700 (Category 2 fee). Where the Fellows providing a period of oversight are located at another facility, the College charges $14 300 (Category 3 fee). Both categories of fee include the initial (Category 1) assessment fee of $4400.

6.143 The Commission is advised that if an overseas-trained practitioner undertakes a period of assessment, it is likely that the Fellows overseeing the assessment will be located in the same hospital. Where the applicant is an AON appointee however, it is likely that one or more of the Fellows will be located off-site.

OVERVIEW OF THE COLLEGE'S TRAINING AND ASSESSMENT

6.144 An overview of the training and assessment processes of the College is provided in Figures 6.2 and 6.3 below.[101]

[101]Figures 4.2 and 4.3 compiled by the Australian Competition and Consumer Commission.

Figure 6.2: College surgical training system

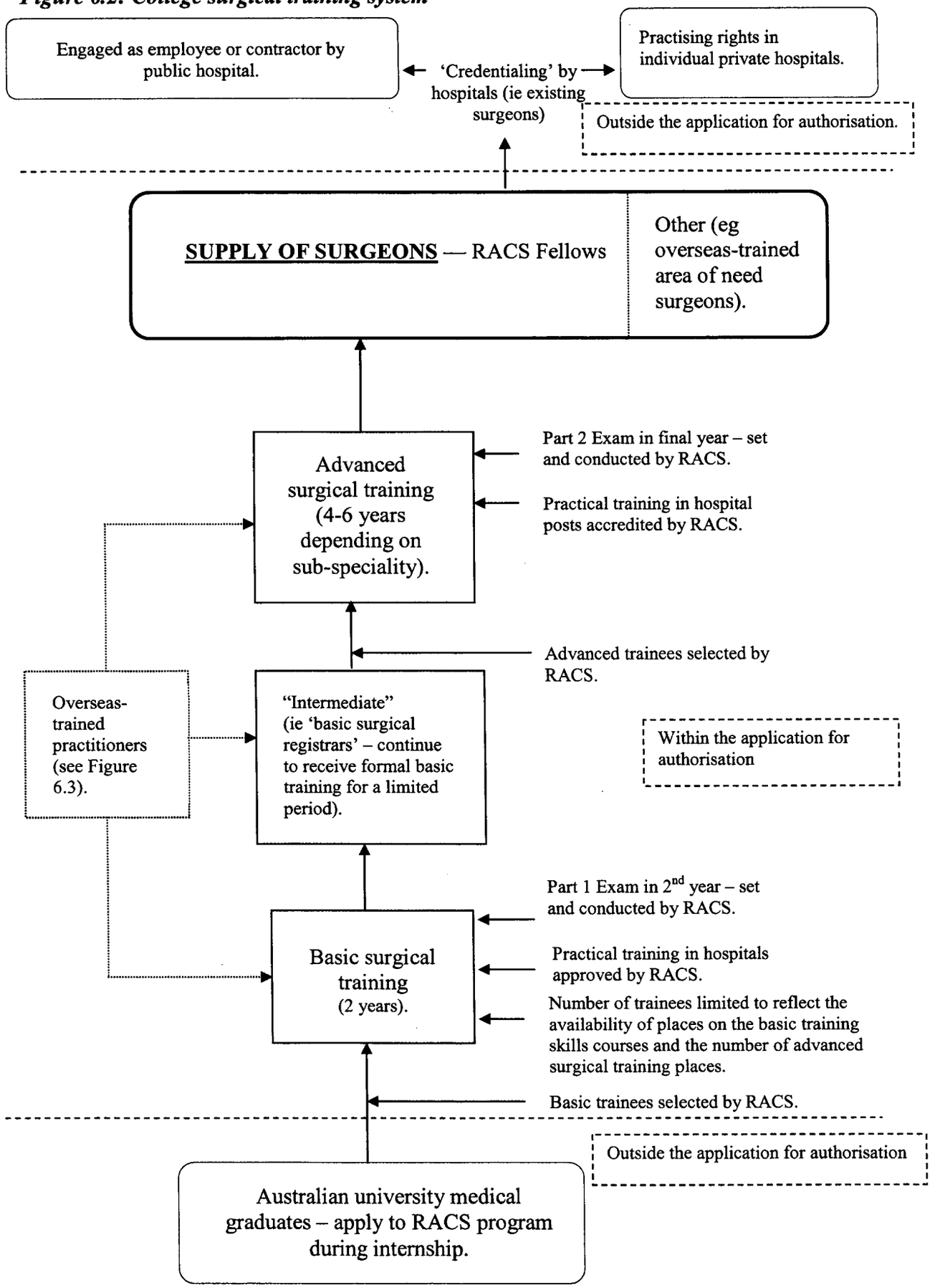
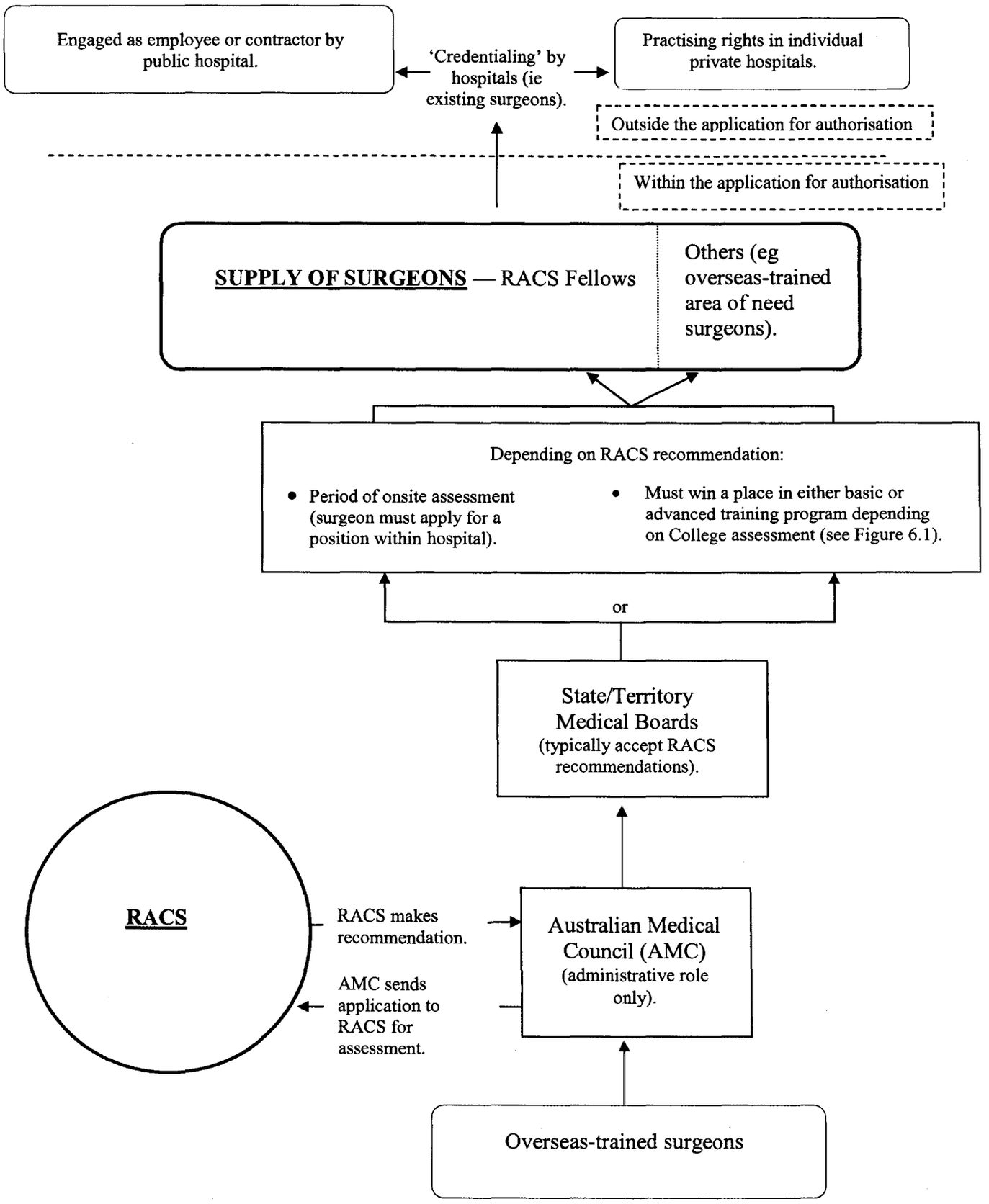


Figure 6.3: College assessment procedure for overseas-trained surgeons



Appeal mechanisms

6.145 Any person adversely affected by a decision of the College referred to below may, within three months of receipt of notice of such decision, apply to the Chief Executive Officer to have the decision reviewed by an Appeals Committee of the College. An Appeals Committee may be convened in relation to the following decisions:

- decisions of the Censor-in-Chief's Committee, Court of Examiners, Board of Basic Surgical Training, Surgical Boards, Regional Sub Committees of Surgical Boards or Supervisors of Surgical Training, in relation to the assessment of progress of Trainees of the College (including admission, dismissal or recognition of training);

- decisions of Boards and Committees in relation to applications for admission to Fellowship;

- decisions of the Censor-in-Chief and Surgical Board Chairman in relation to applications from overseas-trained practitioners for assessment for recognition on behalf of the AMC, or the New Zealand Medical Council, or any applicable State or Territory Medical Board (or for other appropriate purposes);

- decisions of the Censor-in-Chief and Surgical Board Chairman in relation to examinations or training required to be undertaken by overseas-trained practitioners for assessment;

- decisions of the Board of Continuing Professional Development and Recertification in relation to participation of the Recertification Program, and awarding of the Certificate of Continuing Professional Standards;

- decisions of the Council and Executive Committee of the College on the advice of the Censor-in-Chief's Committee in relation to accreditation for training of hospitals, units, teaching centres or supervisors;

- decisions of the Complaints Committees – Council and Regional, in relation to their requirements that complainants be counselled, censured or have the complaint against them referred to Council pursuant to Article 30 of the Articles of Association;

- decisions of the Honorary Treasurer in relation to the financial status of Fellows, Trainees, or other persons; and

- such other decisions for the College, its Boards or Committees as the Council may determine from time to time.

6.146 An appeal may only be lodged on one or more of the following grounds:

- an error in law or in due process occurred in the formulation of the original decision;

- relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision; and/or

- the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

6.147 The College submits that it is rare for hospitals to appeal against a decision not to accredit a post or a decision to disaccredit a post. The reason being that it works in collaboration with the hospitals to ensure standards are met for each post.[102]

6.148 The Appeals Committee consists of the following members:

- the Vice President of the College or another Councillor appointed by the Council;

- two Fellows of the College (from a surgical sub-speciality not involved in the subject matter of the appeal); and

- two other appropriately qualified persons who are not Fellows of the College.

6.149 A non-Fellow member of the appeals committee, usually a senior lawyer, chairs the Committee. Additionally, any individual who was party to the decision of the College to which the appeal relates is not permitted to sit on the Appeals Committee.

6.150 The Appeals Committee operates in accordance with the rules of natural justice and decides each application on its merits. The Committee is conducted informally, is not bound by the rules of evidence, and may invite any person to appear before it or to provide information.[103]

6.151 An applicant to the Appeals Committee has the right to appear before the Appeals Committee. However, an applicant is not entitled to have an advocate or be legally represented unless the Committee has given its consent.

6.152 In addition, the applicant may be required, before an Appeals Committee is convened, to pay a fee of such an amount as determined by the Council of the College. In the absence of a decision to the contrary, an applicant may also be liable for the costs associated with convening the appeal including, travel, accommodation, honoraria and recording costs. The Appeals Committee may recommend to the Council that some or all of the costs be waived.

6.153 Upon consideration of the information, an Appeals Committee may:

- confirm the decision which is the subject of the appeal;

- revoke the decision which is the subject of the appeal;

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[102]College submission in support of the application, March 2001, p32.
[103]Paragraph 12 and 13: Attachment 6 to the College's submission to the Commission dated 30 March 2001, *Appeal Process Amended Rules.*

- revoke the decision and refer the decision to the relevant Board or Committee for further consideration (upon such terms or conditions determined by the Committee);
- revoke the decision and make recommendations to Council on an alternative decision; and
- recommend to the Council whether part or all the costs associated with the Appeals Committee should be waived.

Statistical overview of College training and assessment procedures

Trainees

6.154 As reported in February 2002, there were approximately 1510 trainees registered with the College, 771 of which are registered in the basic surgical training program and 739 trainees have proceeded to the advanced surgical training in one of nine surgical sub-specialities. In addition, there were 22 'endorsed' trainees, who have already completed a Fellowship but are training for another specialty. [104]

Assessment of trainees

6.155 The following tables present the results of the College's Part 1 (Basic Training) Examinations and Part 2 (Fellowship) Examination for the past five years. The Part 1 Exam consists of a multiple choice exam and an objective structured clinical exam. This table is discussed at paragraphs 13.194.

Table 6.3: Result of the Part 1 Multiple Choice Exam from 1995 – 2000[105]

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Total registered	378	383	369	460	488	451
Total passed	129	206	105	218	194	122
% passed	*38*	*60*	*32*	*51*	*44*	*32*
Total failed	213	141	219	208	242	263
% failed	*62*	*40*	*68*	*49*	*56*	*68*
Total no-attendance	36	36	45	34	52	66

6.156 Table 6.4 below demonstrates that during the period from 1995 to 2000, the pass rate in the Part 1 Structured Clinical Examination has been considerably higher than that

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[104] Source: Australian Medical Council *Accreditation Review, Royal Australian College of Surgeons,* February 2002.

[105] College submission to the Australian Medical Council for Accreditation, May 2001, Attachment 35.

of the Multiple Choice Exam. In particular, from 1996 to 1999 approximately 80 per cent of trainees sitting the Part 1 Structured Clinical Examination passed that exam. This number rose to 90 per cent in 2000.

Table 6.4: Result of the Part 1 Objective Structured Clinical Examination 1995 – 2000[106]

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Total registered	215	231	213	190	288	242
Total passed	121	172	157	149	220	205
% passed	*62*	*80*	*78*	*81*	*80*	*90*
Total failed	73	44	44	35	56	24
% failed	*38*	*20*	*22*	*19*	*20*	*10*
Total non-attendance	21	17	12	6	12	13

6.157 Table 6.5 below shows the number of advanced surgical trainees who passed the Part 2 Fellowship Examination increased slightly from 72 per cent in 1999 to 74 per cent in 2000. The College advises that a total of 531 candidates presented for the Fellowship Examination during May 1995 to May 1998. Of this number, there were 183 General Surgical trainees, 126 Orthopaedic trainees, 42 Plastic and Reconstructive surgery trainees, 27 Cardiothoracic trainees, 50 Otolaryngology trainees, 28 Neurosurgical trainees, 22 Paediatric surgical trainees, 49 Urological trainees and 4 Vascular Surgical trainees. Of the 531 candidates:[107]

- 390 candidates passed at the first attempt;
- 75 candidates passed at the second attempt;
- 15 candidates passed at the third attempt;
- 4 candidates passed at the fourth attempt;
- 1 candidate passed at the fifth attempt; and
- 1 candidate passed at seventh attempt.

[106]Ibid
[107]College submission to the Australian Medical Council for Accreditation, May 2001, Attachment 34.

Table 6.5: Result of the Part 2 Fellowship Exam 1995 – 2000[108]						
	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Total registered	165	166	198	205	216	189
Total passed	127	124	134	148	154	135
% passed	*77*	*78*	*70*	*73*	*72*	*74*
Total failed	37	36	57	55	59	48
% failed	*23*	*22*	*30*	*27*	*28*	*26*
Total non-attendance	1	6	7	2	3	6

Table 6.6: Average number of months taken to enter advanced surgical training after completing basic surgical training in Australia, per sub-specialities in 2001[109]	
Surgical sub-speciality	**Number of months**
Cardiothoracic	32*
General surgery	9
Neurosurgery	12
Orthopaedic	19
Otolaryngology – head and neck surgery	16
Plastic surgery	25
Urology	22
Vascular surgery	41

*There was only one cardiothoracic surgical trainee during this period.

Accreditation of hospital training posts

6.158 In 2001 there were 35 hospitals accredited for basic surgical training in NSW, 22 in Victoria, 16 in Queensland and 3 in South Australia, Western Australia and Tasmania.[110]

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[108]College submission to the Australian Medical Council for Accreditation, May 2001, Attachment 35.
[109]The figures in Table 6.6 were compiled by the Commission from Attachment 1 to the College's submission, 14 March 2002.
[110]College submission to the Commission, 14 March 2002, pp1, 4 and 5.

6.159 Table 6.7 shows that the disciplines with the largest number of advanced training positions are general surgery (212) and orthopaedic surgery (133).

Table 6.7: Advanced surgical training positions per surgical sub-speciality for each state and territory, 2001[111]

Surgical Speciality	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Aust
General	78	59	38	14	14	6	0	3	**212**
Cardiothoracic	9	5	2	3	2	0	0	0	**21**
Neurosurgery	13	8	5	2	3	0	0	1	**32**
Orthopaedic	46	31	27	9	17	0	0	3	**133**
Otolaryngology	13	13	8	6	4	1	0	1	**46**
Paediatric	1	3	1	0	1	0	0	0	**6**
Plastic	16	17	3	4	5	1	0	0	**46**
Urology	15	13	8	3	5	0	0	0	**44**
Vascular	3	3	4	2	2	0	0	0	**14**
Total	194	152	96	43	53	8	0	8	**554**
%	35%	27%	17%	8%	10%	1%	0%	1%	

6.160 With regard to accreditation of hospital posts for advanced surgical training, the College considered the accreditation and re-accreditation of 144 hospital posts (involving 41 hospitals) in 1999. Of these, 3 posts had their accreditation withdrawn and 1 new post was not accredited. In 2000, 63 posts were considered (involving 41 hospitals). Of these, accreditation was withdrawn for 1 post and 2 new posts were not accredited.[112]

6.161 In 2001, the College assessed 175 advanced surgical training posts. Of these, 172 were approved, 2 posts were inspected and declined and 1 post was disaccredited. Specifically, one Cardiothoracic Surgery training post at Geelong Hospital was declined accreditation due to insufficient case load and inadequate supervision. Another general surgical training post at Whyalla Hospital was declined due to insufficient case load, inadequate supervision and insufficient Junior Surgical Resident staff. The Plastic and Reconstructive training post at Canberra Hospital was disaccredited for the same reasons identified at Whyalla Hospital. The Commission is

[111] Source: Medical Training Review Panel, *Fifth Report,* December 2001, p30.

[112] 1999 and 2000 accreditation figures are sourced from the RACS letter to the Commission, dated 30 April 2001, p2.

also advised that a number of surgical specialities conduct inspections every five years, and of the 175 posts inspected in 2001, 105 were in Orthopaedics.[113]

6.162 Queensland Health submits that a number of non-accredited training positions have been converted into accredited training positions in recent years.[114] Hospitals containing both accredited and non-accredited posts in Queensland include:

Table 6.8: Accredited and non-accredited training posts in Queensland public hospitals[115]

Hospital/sub-speciality	Accredited	Non-accredited
Cairns:		
Orthopaedics	2	1
Gold Coast:		
General surgery	4	1
Orthopaedics	2	2
Urology	1	1
Logan:		
General surgery	1	2
Orthopaedics	0	3
Mater:		
General surgery	3	2
Orthopaedics	3	1
Princess Alexandra:		
General surgery	5	3
Orthopaedics	4	2
Cardiothoracic	0	2
Neurosurgery	1	1
QEII:		
General surgery	0	3
Orthopaedics	1	3
Royal Brisbane Hospital:		
General surgery	4	5
Orthopaedics	5	2
Rockhampton:		
General surgery	1	2
Orthopaedics	0	1
Townsville:		
General surgery	3	5

[113]The information contained in this paragraph is source from the College's submission to the Commission, 14 March 2002, p1.
[114]Queensland health submission, 24 September 2001, p2.
[115]Ibid, Attachment.

Table 6.8: Accredited and non-accredited training posts in Queensland public hospitals[115]		
Hospital/sub-speciality	**Accredited**	**Non-accredited**
Cardiothoracic	0	2
Neurosurgery	0	1
Orthopaedics	2	1

6.163 Data provided to the Commission by NSW Health indicates that approximately 71 per cent of funded surgical registrar positions are accredited.[116] The proportion of accredited positions varies across the surgical specialities. Specifically, the highest proportion of positions accredited are in urology, ear nose and throat, vascular and paediatric surgery (100 per cent), while the lowest proportion of accredited positions occurred in orthopaedic surgery (56 per cent). There are presently an estimated 25 funded non-accredited general surgical positions and 30 funded non-accredited orthopaedic positions within the NSW public hospital system. The estimated number of accredited and non-accredited surgical training positions in NSW public hospitals is summarised in Table 6.9.

Table 6.9: Accredited and non-accredited training posts in New South Wales public hospitals[117]		
Sub-speciality	**Accredited registrar positions**	**Non-accredited registrar positions**
Cardiothoracic Surgery	12	4
ENT	12	
Neurosurgery	12	5
Orthopaedics	38	30
Paediatric	2	
Plastic and reconstructive	10	4
General Surgery	71	25
Urology	14	
Vascular Surgery	5	
Other	1	
TOTAL	177	68

[116]Positions which are currently non-accredited may be so because the College has not been asked to accredit them (NSW Health submission April 2002).

[117]NSW Department of Health submission to the Commission, April 2002, Appendix A.

6.164 The Commission is advised that as at September 2002 there were a total of 42 service registrar posts in Western Australia (that is, non-accredited surgical training posts). These posts were in general surgery, cardiothoracic surgery, neurosurgery, plastic surgery and vascular surgery.[118] The Commission is also advised that as at 1 July 2001, there were 15 accredited surgical training positions in the ACT. At the same time, there were 5 non-accredited surgical training positions in the ACT.[119]

Assessment of overseas-trained surgeons[120]

6.165 The College receives applications from overseas-trained practitioners for assessment throughout the calendar year. In 2000, the College received 80 such applications. There were 21 interviews and assessments conducted in 2000 and 40 in 2001. The interviews and assessments involved the following specialities:

Table 6.10: The number of interviews of overseas-trained surgeons conducted in 2000 and 2001, per surgical specialty	
General Surgery	23
Orthopaedics	16
Otolaryngology - Head and Neck Surgery	10
Neurosurgery	4
Urology	4
Vascular	2
Cardiothoracic Surgery	1
Plastic and Reconstructive Surgery	1

6.166 Between January 1993 and March 2001, 297 applications for assessment were received from overseas-trained surgeons. Table 6.11 provides a breakdown of this figure:

Table 6.11: Results of assessment of overseas-trained practitioners, 1993-2001. [121]	
Applications approved	37
Applications rejected	11
Further training required and/or examination	89
Applications awaiting College assessment or are required to submit further information	93

[118] The Western Australian Minister for Health, the Hon Bob Kucera, submission to the Commission, 18 September 2002, p2.
[119] Submission from ACT Department of Health, Housing and Community Care, 28 September 2001.
[120] Unless otherwise stated, the figures appearing under this heading were provided by the College in its submission dated 14 March 2002, pp 6-12.
[121] Australian Medical Council submission to the Commission, May 2001, Table 2, p7.

Applications withdrawn	35
Applications lapsed	32

6.167 In 2000 and 2001, 61 interviews and assessments of overseas-trained surgeons were conducted. Table 6.12 shows the number of months taken to complete these assessments.

Table 6.12: Number of months taken to complete interviews and assessment of overseas-trained surgeons in 2000 and 2001.[122]	
Completed within 3 months	7
Completed within 3-6 months	12
Completed within 6-9 months	13
Completed within 9-12 months	20
Completed after 12 months	9

6.168 The Commission is advised that the remaining 19 overseas applicants had not completed the requisite application procedures of the College or the Australian Medical Council or had withdrawn their application for assessment.[123]

6.169 Applications were received from 26 different countries in 2000. In particular, the countries where applicants completed the most recent training and the number of applicants from each country are set out in Table 6.13 below.

Table 6.13: The number of applications for assessment from overseas-trained surgeons in 2000, by country of origin.	
Country	**Number of applicants**
United Kingdom	20
South Africa	9
India	8
Yugoslavia	6
Egypt	5
USA	4
Iraq	3
Pakistan	3

[122]College submission to the Commission, March 2002, p7.
[123]Ibid.

China	2
Poland	2
Sri Lanka	2
Sweden	2
Austria	1
Bosnia	1
Bulgaria	1
Burma	1
Ethiopia	1
Germany	1
Israel	1
Malaysia	1
Mexico	1
Russia	1
Sudan	1
Switzerland	1
Turkey	1
Vietnam	1

6.170 A summary of the College recommendation made for each of the above listed applications appears at Attachment B to this determination.

7. THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE AND THE AUSTRALIAN MEDICAL WORKFORCE ADVISORY COUNCIL

History of workforce planning in Australia

7.1 The Commonwealth Department of Health and Ageing submitted:

> [u]ntil the late 1980s, Australian governments largely allowed the size, structure and other features of the medical workforce to be determined in an unregulated environment. In the 1960s and 1970s, national health spending as a proportion of GDP began to increase rapidly. Advances in medical science increased patient expectations for health care and medical education expanded considerably. This expansion then created an oversupply of practitioners as population growth slowed, new technology realised productivity gains, numbers of practitioners migrated to Australia, and health care treatment approaches changed to include greater use of day surgery and shorter hospital stays.
>
> Attention focussed on the size and distribution of the medical workforce as medical services expenditure increased rapidly, while the market failed to correct geographic and sectoral undersupply of practitioners. Governments began to focus on containing costs in all areas of the health system and ensuring that the best use was made of resources in realising health outcomes. From the 1984 introduction of Medicare, most medical services were substantially subsidised by 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.
>
> At the same time, distribution of the workforce remained very uneven, with persistent shortages in rural and remote areas, despite oversupply of general practitioners (GPs) in capital cities. Apparent shortages in some specialist disciplines, particularly affecting rural and remote areas and the public hospital system, became a focus of attention in the early 1990s, together with lack of reliable data with which to analyse the extent and location of these shortages.
>
> It was in this context that Australian governments began to more closely analyse and plan the medical workforce to match the workforce with population health needs. Planning and intervention since then has amounted to a complex task of slowing the overall growth of the workforce (and establishing an appropriate practitioner to population ratio), while increasing the supply of practitioners in certain geographic areas and in particular specialties. A second arm of planning, of importance for both health outcomes and cost containment, has been to ensure that the workforce is properly trained.
>
> The measures introduced to achieve these ends have included capping of medical school intakes and restrictions on practitioners' access to Medicare benefits. This fine-tuning has not been simple to achieve, as individual practitioners (rather than governments) have ultimate choice over where they work, and because the fee-for-service public subsidy of medical care blunts market pressures, which would otherwise move doctors to where they are needed.[124]

7.2 The establishment of the Australian Medical Workforce Advisory Committee (AMWAC) in 1995 was a key measure introduced by Commonwealth, state and territory governments to assist medical workforce planning. Workforce planning refers to the process of estimating the required supply of health care practitioners to meet an expected future level of service requirement as defined.[125] AMWAC is an advisory committee to the Australian Health Ministers Advisory Council

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[124]Commonwealth Department of Health and Aged Care submission, 13 June 2001, pp6-7.
[125]The AHMC submission to the Commission, 22 June 2003, AMWAC Methodology, p6.

(AHMAC)[126] and through AHMAC to the Australian Health Ministers' Conference (AHMC).

7.3 AMWAC provides advice on national medical workforce matters, namely:

- the structure, balance and geographic distribution of the medical workforce in Australia;
- the present and required education and training needs as suggested by population health status and practice developments;
- workforce supply and demand;
- medical workforce financing; and
- models for describing and predicting future workforce requirements.

7.4 In particular, AMWAC recommends targets for the number of trainees in particular medical specialities, including the surgical sub-specialties. AHMAC and ultimately the AHMC then determine whether to endorse these targets.

7.5 AMWAC comprises an independent chair and representatives from Commonwealth governments, state and territory health authorities, the chair of the Australian Health Workforce Officials Committee (AHWOC), the Australian Institute of Health and Welfare, the Australian Medical Council, peak organisations representing various sections of the medical workforce (including the Australian Medical Association, the medical colleges and university medical schools), a member with consumer expertise, and a member with expertise in economics/health economist or labour market economics.[127]

7.6 AMWAC has an annual work plan which is approved by AHMAC.[128] To implement its work plan each year, AMWAC establishes working parties to report on various aspects of the Australian medical workforce. AMWAC's preferred composition for each working party is to have, at minimum, an independent chair (drawn from the membership of AMWAC); two nominees from the profession under review (drawn from the main peak body/bodies representing that profession), two nominees of government (drawn from nominations supplied by government health departments), and a consumer nominee (provided by either the Consumers' Health Forum or the Health Issues Centre).[129]

7.7 By 2001/02, AMWAC had completed 24 individual workforce reviews, covering around 70 per cent of the specialist workforce. Of these, there have been reviews into 6 sub-specialties in which the College conducts training, namely:

- orthopaedic surgery (1996 and 1999);
- urology (1996)

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[126] A committee comprising senior officials from Commonwealth, state and territory health departments which supports the Australian Health Ministers' Conference.
[127] The AHMC submission to the Commission, 22 June 2003, AMWAC Methodology, p11.
[128] Ibid, p12.
[129] Ibid, p13.

- general surgery (1996)
- ear, nose and throat surgery (1997); and
- neurosurgery (2000)
- cardiothoracic surgery (2001)[130]

In addition, AMWAC is to update its reports on orthopaedic surgery, ear, nose and throat surgery and neurosurgery in 2003-04.[131]

AMWAC approach to workforce planning

7.8 Generally, AMWAC's approach to reviewing individual medical disciplines is to access data from existing data bases (eg AIHW, Medicare and Australian Bureau of Statistics) and to collect whatever other information is required for the relevant workforce working party to:[132]

- Describe:
  - the unique services provided to the community by a particular workforce and the other service providers and infrastructure to provide a sustainable service of acceptable quality;
  - the current level of supply in terms of workforce numbers, characteristics (age, gender, qualifications), participation (full time/part time, hours worked, by age and gender), distribution (by state/territory and other geographic measures, public sector and private sector), productivity, service provision (by type and quantity of service), and skills and tasks;
  - recruitment process, including the number, characteristics and training status of people currently undertaking training in Australia, and the number and characteristics of qualified people entering the workforce through migration; and
  - current level of wastage due to migration, people choosing an alternative career path, retirement and death.
- Evaluate:
  - the adequacy of the current level of workforce supply based on a range of indicators (eg international and national benchmarks, service waiting time, population health status, perception of key stakeholders), with a view to quantifying the level of shortage or oversupply if indeed either situation is found to exist;

In its submission following the draft determination the AHMC outlined that:

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[130] AMWAC Annual Report 2000-2001, p1.
[131] AHMC submission, 22 June 2003, p4.
[132] The AHMC submission to the Commission, 22 June 2003, AMWAC Methodology, p7.

> An 'indicator' approach is used to assess the adequacy of current supply. With this approach, a set of indicators or criteria are chosen, measures of each indicator are calculated, and an evaluation of whether each measure is consistent with a specified standard for adequate supply is made. Assessing the adequacy of a workforce is the most difficult part of workforce analysis. This is due to the absence of relevant data collections in some cases or the difficulty with separating the workforce effect from the effect of other factors such as funding which are determined by governments, or with determining at what level an indicator suggests workforce surplus or shortage. Judgement is required in making many of these assessments, and AMWAC uses the specialist expertise of the Working party reviewing the particular disciplines as a professional reference group in making these judgements.
>
> AMWAC's methodology is considered to be appropriate and effective.[133]

- the adequacy of geographic distribution of the workforce using indicators such as level of service provision and population based benchmarks;
- the extent to which other service providers are currently doing some of the work traditionally provided by the workforce under review; and
- the extent to which the current workforce is providing services in line with government health goals and priorities.

- Predict:
  - workforce requirements for a stated period of time (eg next ten years) using a range of scenarios and requirement projection indicators, population needs based and demand-based and service provision benchmarks;
  - workforce supply for a stated period of time using a range of scenarios (eg 'no change in the level of recruitment', 'increasing/decreasing the number of people undertaking training', 'increasing/decreasing the supply of qualified people entering the workforce from overseas', 'increases/decreases in level of workforce participation', and 'increases/decreases in attrition'); and
  - the potential for changes in practice, service delivery and technology which are likely to effect population requirements for services or are likely to alter levels of the workforce productivity.

AMWAC reviews of surgical sub-specialities

7.9 A summary of each of the surgical workforce reviews conducted by AMWAC to date is provided below.

Orthopaedic surgery[134]

7.10 AMWAC released an updated report in 1999 on the orthopaedic surgery workforce in Australia, including updated projections of workforce supply requirements until 2009.

7.11 The Commission notes that three of the six members of the orthopaedic surgery working party were surgeons, two being orthopaedic surgeons.

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[133]Ibid, p2.
[134]See *The Orthopaedic Surgery Workforce in Australia an update: 1998 to 2009,* AMWAC, March 1999.

7.12 The original 1996 review of orthopaedic surgery workforce estimated the total practising workforce to be 674, assessed the current workforce as being adequate, but recommended an increase in the number of orthopaedic surgery training positions on the assumption that requirements would grow by an estimated 3 per cent per annum.

7.13 In the 1999 review of orthopaedic surgery, AMWAC estimated the size of the practising orthopaedic surgery workforce in 1998 was 710 (3.8 surgeons per head of 100 000 population or 1:26 240). The majority (63 per cent) of orthopaedic surgeons were aged between 35 and 54 years. 30.2 per cent of orthopaedic surgeons were aged between 45 and 54 years and 20.5 per cent of the workforce was aged between 55 and 64 years. Fourteen per cent of the workforce was aged 65 years and over, which was above the national average for all medical practitioners of 10 per cent.

7.14 AMWAC found that in 1998 there were 117 orthopaedic surgery trainees across the four years of the orthopaedic surgery training program, with the training program graduating between 26 and 30 new orthopaedic surgeons per year. The number of trainees had increased from 1996 in all states except South Australia.

7.15 In assessing the adequacy of the orthopaedic workforce, AMWAC examined the following indicators:

- surgeons-to-population and orthopaedic services per 100 000 population. The Australian Orthopaedic Association suggested that the population catchment required to sustain an orthopaedic surgery service ranged between 22 000 and 30 000;
- public hospital employment vacancies;
- hours worked; and
- elective surgery waiting times.

7.16 Based on these indicators, AMWAC concluded that the orthopaedic surgery workforce was adequate. However, the 1999 review recommended that there be an increase in the number of funded orthopaedic surgery training positions and trainees to match an adjusted expected future growth in requirements over the ten years of 2.7 per cent per year. It recommended that the number of first year orthopaedic surgery trainees should be increased from 33 in 2000, to 44 first year trainees from 2002 onwards. The working party concluded that there should be a staged increase in the number of first year training positions, distributed as set out in Table 7.2 below.

Table 7.2: First year intake of orthopaedic advanced surgical trainees recommended by AMWAC in 1999[135]

State	1998 1st year intake	2001 1st year intake	2002-2005 1st year intake
NSW/ACT	11	14	15
VIC	7	10	11
QLD	7	9	9
SA	2	2	3
WA	5	4	5
TAS	0	1	5
Aust	**32**	**40**	**44**

[135]Ibid, p8.

Urology[136]

7.17 AMWAC's 1996 report on the urology workforce in Australia made projections of workforce supply requirements to 2006.

7.18 The Commission notes that the six member Urology Working Party was comprised of one representative from the College and two from the Urological Society of Australasia.

7.19 The report concluded that the urology workforce is adequate. At the time, there were 200 practising urologists and 33 approved training positions throughout Australia. The average age of the urology workforce was 49.7 years. 32.4 per cent of urologists were aged 40 to 49 years, 50.7 per cent aged under 50 years, 18.1 per cent aged over 60 years and 31.2 per cent of urologists were aged in the 50 to 59 year age group. AMWAC also reported that urology surgeons worked an average of 49.8 hours a week.

7.20 On balance, the working party concluded that the urology workforce was adequately meeting demand. In particular, the working party found that the Australian specialist urology to population ratio was 1:90 119. In 1995, urology patients made up 9.8 per cent of the national waiting list and the average waiting times in each state and territory for a first urological consultation ranged from 3 to 4.6 weeks. Patients referred with an urgent condition could be seen, on average, within 1.8 to 4.6 days in private rooms and 1 to 12.5 days as public outpatients.

7.21 AMWAC estimated that the demand for urological services in hospitals will increase by 46.7 per cent over the next 20 years, mainly due to Australia's ageing population. It estimated that an average of 9 new urology specialists would enter the workforce each year up to 1996 and 12 would enter the workforce from 1997 to 2001, a growth of 1.4 per cent per annum. The working party concluded that this projected level of graduate output would not be sufficient to meet expected future requirements, which was estimated to grow by 1.6 per cent per annum.

7.22 As such, the working party recommended that state and territory health departments undertake negotiations with the Urological Society of Australia for the establishment of additional urological training positions, initially up to 5 by 2001, distributed as set out in Table 7.3.

Table 7.3: Number of urological training positions recommended by AMWAC[137]

State/Territory	1996	2001	2006	Increase 1996 to 2001	Increase 1996 to 2006
NSW/ACT	12	15	16	3	4
VIC	10	10	11	0	1

[136] *The Urology Workforce in Australia Supply Requirements and Projections 1995-2006,* AMWAC, May 1996.
[137] Ibid, p8.

Table 7.3: Number of urological training positions recommended by AMWAC[137]					
State/Territory	**1996**	**2001**	**2006**	**Increase 1996 to 2001**	**Increase 1996 to 2006**
QLD	6	8	10	2	4
SA/NT	3	3	3	0	0
WA	3	4	4	1	1
TAS	0	1	1	1	1
Australia	*36*	*41*	*45*	*5*	*9*

General/vascular surgery[138]

7.23 AMWAC released a report in 1997 on the general surgery workforce in Australia, including projections of workforce supply requirements to 2007. This report preceded the establishment of vascular surgery as a separate sub-speciality.

7.24 The General Surgery Working Party consisted of four surgeons, two representatives from AMWAC and one representative from a state health commission and health department.

7.25 Using data from the College, AMWAC reported that in 1996 there were 1225 general/vascular surgeons in Australia. The surgeon-to-population ratio for general and vascular surgeons combined was 1:14 930 and 6.7 surgeons per 100 000 population. The report noted the significant feature of the workforce was the large number of general surgeons aged 55 years and over (38.7 per cent). The vascular surgery workforce was comparatively younger, with 81.2 per cent of the workforce aged under 55 years.

7.26 As at June 1996, there were 176 approved general surgery advanced training positions. Between 1989 and 1996, there was a 39 per cent increase in trainee numbers. This varied considerably between the states and territories with a 100 per cent increase in Western Australia and an 18.2 per cent increase in trainees in South Australia. The increase in Western Australia was necessary to bring the state's trainee numbers to a level appropriate to its population.

7.27 The working party examined the following indicators in assessing the adequacy of the general surgery workforce:

- surgeon to population ratio;
- public hospital vacancies;
- elective surgery waiting times;
- waiting times for consultations; and

[138] *The General Surgery Workforce in Australia Supply and Requirements 1996-2007,* AMWAC, May 1997.

- surgeons' perceptions of the adequacy of the current workforce.

7.28 The working party concluded that the general/vascular surgery workforce was adequately meeting requirements. In particular, the working party found that surgeon to population ratio had been reasonably constant over the previous 12 years; there were ten general surgery public hospital vacancies and only one vascular surgery vacancy; the waiting times for urgent general surgery were appropriately short; and only 10 per cent of general surgeons felt that more general surgeons were required in their geographic area.

7.29 However, the working party considered that an increase in the number of funded general surgery training positions and trainees would be required to match future growth requirements of 1 per cent per year. This would involve increasing the number of graduates from the general surgery training program in 2002 from 42 per year to 52 per year. The report noted that supply trends over the next ten years will be dominated by the large number of surgeons aged 55 years and over and their progression through to retirement. To reach the target of 52 general surgery graduates by 2002, the working party recommended an additional 40 general surgery advanced training positions would be required. It was recommended that this increase be staged and distributed as set out in Table 7.4.

Table 7.4: Number of general surgery training positions recommended by AMWAC[139]

State/Territory	Total in 1996	Total in 2000	Increase in 1998	Increase in 1999	Increase in 2000
NSW/ACT	58	75	7	7	3
VIC/TAS	58	62	1	2	1
QLD	32	43	5	5	1
SA/NT	13	15	1	0	1
WA	15	21	2	2	2
Australia	*176*	*216*	*16*	*16*	*8*

Neurosurgery[140]

7.30 AMWAC released a report in 2000 on the neurosurgery workforce in Australia, including projections of workforce supply requirements to 2010.

7.31 The Commission notes that there were six members of the Neurosurgery Working Party. In particular, the working party consisted of two surgeons, two representatives from state health departments, a policy officer from AMWAC and a neurosurgery hospital department representative.

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[139]Ibid, p57.

[140]*The Neurosurgery Workforce in Australia Supply and Requirements 1999-2010,* AMWAC, August 2000.

7.32 At the time of reporting, the size of the neurosurgery workforce was estimated to be 104. The national neurosurgeon to population ration was 1:183 763 (or 0.5 neurosurgeons per 100 000 population). In comparison, in Canada the 1996 national neurosurgeon to population ratio was estimated at 1:171 168. The ratio in the United Kingdom in 1996 was 1:500 000 and in 1997 the ratio in the United States was 1:50 000. The average age of neurosurgeons in 1997 was 51.1 years and a total of 41.3 per cent of the workforce was over the age of 55 years. There were very few neurosurgeons under the age of 35 years of age (3.5 per cent of all neurosurgeons). On average, neurosurgeons worked 58.3 hours per week and spent an average of 49.9 of these hour per week on direct patient care.

7.33 The working party found that the neurosurgery workforce is unevenly spread among the states and territories, with NSW/ACT, Queensland and Western Australia being relatively poorly supplied, as compared with their share of the population.

7.34 The working party examined the following indicators in assessing the adequacy of the neurosurgery workforce:

- neurosurgeon to population ratio. The Neurosurgical Society of Australasia suggested that ideally there should be at least one neurosurgeon per 175 000 population. The actual national neurosurgeon to population ration was 1:183 763;
- public hospital vacancies;
- waiting times for elective surgery and consultations; and
- perceptions of the adequacy of the current workforce.

7.35 The working party concluded that based on the range of indicators the neurosurgery workforce was adequately meeting requirements. In particular, in May/June 2000 there was only one neurosurgery vacancy within the public hospital system, located in NSW. The median waiting time for neurosurgery was 6 days for urgent patients and 18 days for non-urgent patients. The average waiting time for a standard first consultation with a neurosurgeon in his/her private room was 27.9 days while a patient within the public sector would wait 62.6 days. In addition, 38.5 per cent of surgeons who responded to the AMWAC 2000 survey indicated that they felt that more neurosurgeons were required in their geographic area.

7.36 The working party recommended that in order to achieve an appropriate supply of neurosurgeons, the annual average intake into the neurosurgery training program should be maintained at between 6 and 8 trainees per year from 2001 onwards. By comparison, there were 5 trainees entering in 1998, 6 in 1999 and 9 in 2000. The report recommended that an update of the review of the neurosurgery workforce be undertaken in 2004-2005.

Ear, nose and throat surgery[141]

7.37 AMWAC released a report in 1997 on the ear, nose and throat (ENT) surgery workforce, including projections of workforce supply requirements to 2007.

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[141] AMWAC, *The Ear Nose and Throat Surgery Workforce in Australia Supply and Requirements 1997-200,* October 1997.

7.38 The Commission notes that of the nine members of the ENT Working Party, four members were surgeons (three of which being ENT surgeons). The remaining members were health department and AMWAC representatives.

7.39 Medicare data indicated that as at 1995-96 there were 317 ENT surgeons in Australia. Using Medicare data, the ENT surgeon to population ratio was estimated at 1:57 550. The working party also found that the ENT surgeons were older when compared to other specialists. For example, the average age of all male specialists in 1995 was 48.3 years (43.4 for females) while the average age of ENT specialists was 53. In 1995, 40.6 per cent of ENT surgeons were aged 55 years and over and of these surgeons, 41 per cent were aged 65 years and over. 24 per cent of the workforce was aged under 45 years. AMWAC noted that the significant proportion of ENT surgeons aged 55 years and over indicated that there would be a substantial number of surgeons leaving the workforce over the next ten to fifteen years given an average retirement age of 68 years.

7.40 As at June 1997, there were 40 approved ENT surgery advanced training positions in Australia. There were 39 ENT trainees. From 1992 to 1997, there was a 21.2 per cent increase in the number of advanced ENT trainees. The increase varied across the states and territories with a 33.3 per cent increase in Victoria/Tasmania, a 30 per cent increase in NSW and no change in the number of trainees in Queensland, South Australia and Western Australia.

7.41 While there were no clear benchmarks in relation to the ENT surgeon to population ratio, the working party concluded that the workforce was just satisfactory. However, without prompt corrective action, it concluded that the workforce will move towards a situation of escalating undersupply. In particular, the working party recommended that graduate output be increased from the recent average of 10 graduates per year to 15 graduates per year. To achieve this increase, an additional 20 ENT surgery training positions would need to be established as set out in Table 7.5.

Table 7.5: The number of ear, nose and throat advanced surgical training positions recommended by AMWAC[142]

State/Territory	Total in 1997	Total in 2000	Increase in 1998	Increase in 1999	Increase in 2000
NSW/ACT	13	21	3	3	2
VIC/TAS	12	16	2	1	1
QLD	6	11	2	2	1
SA/NT	5	6	1	-	-
WA	4	6	2	-	-
Australia	*40*	*60*	*10*	*6*	*4*

Cardiothoracic surgery[143]

[142]AMWAC, *The Ear, Nose and Throat Surgery Workforce in Australia*, October 1997, p13.

7.42 AMWAC released a report in 2001 on the cardiothoracic surgery workforce, including projections of workforce supply requirements to 2011.

7.43 The Cardiothoracic Surgery Working Party was comprised of a representative from both the College and the Australasian Society of Cardiac and Thoracic Surgeons, three surgeons (two of which were nominated by state and territory health departments), a consumer nominee as well and an officer from AMWAC.

7.44 AMWAC estimated the size of the cardiothoracic workforce at 107. All cardiothoracic surgeons were located in metropolitan areas. It was noted that cardiothoracic surgery services were generally not sustainable in rural areas due to the infrastructure required to support cardiothoracic surgery and the population base required to maintain a viable cardiothoracic surgery practice. The national cardiothoracic surgeon to population ratio was 1:180 347.

7.45 The average age of cardiothoracic surgeons was 48 years, with a large proportion being less than 45 years of age (39.6 per cent). Only 25.4 per cent of the workforce were aged 55 years or older. In 1998, medical labour force data showed that, on average, cardiothoracic surgeons worked 64.1 hours per week, which was among the highest of any medical specialist workforce.

7.46 The working party concluded that the cardiothoracic surgery workforce was adequately meeting requirements. In order to achieve an appropriate supply of cardiothoracic surgeons, the report recommended that an intake to the cardiothoracic surgery training program should be maintained at approximately 5 per year.

Implementation of AMWAC recommendations

7.47 As mentioned previously, AMWAC monitors progress on implementing its targets for the number of medical trainees and reports annually on this to AHMAC and the AHMC.

7.48 In its 2001-02 Annual Report, AMWAC reported that overall implementation of AMWAC recommendations is mainly on schedule. Of the reviews that have been completed for surgical specialities, ENT surgery and orthopaedic surgery continue to make slow progress with implementing recommendations. Specifically, for ENT surgery only six new training positions have been created since 1997, which is well short of the recommended target of 20 new training positions by 2000. In orthopaedic surgery there were 37 first year advanced trainees in 2002, which is short of the recommended target of 40 first year trainees by 2001. Generally, AMWAC reports that slow implementation of AMWAC recommendations appears to be 'due to funding and training infrastructure difficulties'.[144]

7.49 A summary of the progress in implementing the AMWAC recommendations in each of the relevant surgical specialities for 2002 is provided below:[145]

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[143]AMWAC Annual Report 2000-01, August 2001.
[144]AMWAC Annual Report 2001-02, p 11.
[145]AMWAC Annual Report 2001-02, pp15-16.

Table 7.6: Implementation of AMWAC recommendations in surgical sub-specialities				
Surgical specialty (and year of AMWAC review)	**State/ territory**	**AMWAC recommendation**	**Implementation**	**Whether AMWAC recommendation met**
General Surgery (1997)		Recommended total number of positions by 2000	Total number of training positions in 2002	
	NSW/ACT	75	NSW-96	Yes
	Vic/Tas	62	Vic-72; Tas-5	Yes
	Qld	43	43	Yes
	SA/NT	15	SA-12; NT-1	No
	WA	21	17	No
	Total	*216*	*248*	*Yes*
Orthopaedic Surgery (1999)		Recommended number of first year advanced trainees by 2001	Number of first year advanced trainees in 2002	
	NSW/ACT	14	NSW-13	No
	Vic	10	7	No
	Qld	9	7	No
	SA/NT	2	SA-1	No
	WA	4	6	Yes
	Tas	1	1	Yes
	Total	*40*	*37*	*No*
Urology (1996)		Recommended total number of training positions by 2001	Total number of training positions by 2002	
	NSW/ACT	15	NSW-16; ACT-1	Yes
	Vic	10	12	Yes
	Qld	8	8	Yes
	SA/NT	3	SA-3	Yes
	WA	4	5	Yes
	Tas	1	-	No
	Total	41	45	Yes
Neurosurgery (2000)		Recommended number of first year advanced trainees	Number of first year advanced trainees in 2002	
		6 to 8 each year between 2001 and 2010	6	Yes
Cardiothoracic Surgery (2001)		Recommended number of first year advanced trainees	Number of first year advanced trainees in 2001	
		5 each year between 2001 and 2011.	6	Yes
Ear, Nose and Throat Surgery (1997)		Recommended total number of training positions by 2000.	Total number of training positions in 2002	
	NSW/ACT	21	NSW-15	No
	Vic/Tas	16	Vic-13	No
	Qld	11	9	No
	SA/NT	6	SA-7	Yes
	WA	6	5	No
	Total	*60*	*48*	*No*

ACCC submission to 2001 Review of AMWAC

7.50 In February 2000, the Australian Health Ministers' Advisory Council (AHMAC) agreed to conduct the first five-year review of AMWAC. The review of AMWAC and its operations commenced in 2001. Broadly, the review examined AMWAC's performance against AMWAC's terms of reference.

7.51 The Commission provided a submission to the review in September 2001. The following two reports prepared by for the Commission by Professor Jeff Borland of the University of Melbourne were attached to the submission:

- An evaluation of the AMWAC 1999 review of the orthopaedic surgery workforce in Australia; and
- Recommendations on the AMWAC process for the provision of advice on medical workforce matters.

7.52 In its submission to the review, the Commission, among other things:

- noted Professor Borland's conclusion that while the overall methodology applied by AMWAC appears satisfactory, there are deficiencies and lack of rigour in the detail of its implementation. The Commission expressed concern that this has affected the various conclusions contained in AMWAC reviews, and may have caused workforce needs and required training positions to be systematically under-estimated. The Commission supported recommendations made by Professor Borland on this issue; and
- agreed with Professor Borland's recommendation that AMWAC working parties should contain appropriately qualified persons in economics and quantitative methods. In addition, the Commission submitted that these persons should be sufficiently senior and recognised in their field to have the ability to counterbalance the influence of the members of the profession.

7.53 In an additional submission to the review, the Commission suggested, as a matter of priority, that AMWAC undertake a review of the current adequacy of supply of specialist medical services, particularly in the specialist surgical area.

7.54 More generally, the Commission also submitted that a major issue for a body such as AMWAC is to assess whether supply is adequate, both currently and for the future.

Outcome of the AMWAC review

7.55 The AMWAC review team completed its report in early 2002. Key recommendations included:

- that AMWAC be retained;
- that AHMAC commend AMWAC on its achievements;
- to enhance the objectivity, relevance and robustness of AMWAC recommendations, that AMWAC working parties include stronger input from economic and statistical experts, government jurisdictions and consumers. In addition, AMWAC should establish guidelines regarding membership of working parties and consultation processes, and establish a reference panel including expert

clinicians, representatives of consumer organisations and health service managers, to be drawn on for participation in AMWAC working parties;

- that AMWAC, in preparing its workforce reports, should consider evidence in several specified crucial areas including: consumer expectations (eg access, consumer trends); demographic (eg changing population, rural issues); economic (eg changes in health insurance coverage and utilisation, effect of the Australian dollar on the supply of overseas-trained doctors, changes in medical indemnity); medical workforce (eg full-time versus part-time work, implications of decisions on safe working hours, gender distribution, use of overseas-trained doctors, changes in training); general health system (eg impact of shortages in nursing and allied health, health delivery and patient practice); epidemiological (eg changing disease patterns, Aboriginal and Torres Strait Islander health issues);and international considerations (eg migration policy);

- that AMWAC should include advice in its reports on possible approaches to achieving desirable workforce supply in accordance with quality health care practices, including increasing training numbers, addressing maldistribution, importing additional practitioners and possible workforce substitution;

- that AMWAC should review its methodology and revise its reporting to take into account issues raised in submissions to the review, specifically including the Borland reports lodged by the Commission; and

- that AMWAC should take into account quantitative and qualitative education, training and supply issues when conducting specific workforce studies, including: changing public hospital practices, trends in career choices by doctors, technology changes, the role of the private sector, changes in undergraduate and specialist education.

7.56 The review team also noted that the implementation of AMWAC recommendations was an area of particular concern, and one where far better co-ordination is required, including clarification of roles and responsibilities. While confirming that the implementation of AMWAC recommendations is not the responsibility of AMWAC, the review team considered that AMWAC should provide advice to those responsible on possible approaches to implementation for consideration by those responsible for implementation (that is, Commonwealth, state and territory governments, specialist colleges and the higher education sector). It also concluded that AHMAC should determine the appropriate implementation mechanisms, including accountabilities and reporting requirements.

7.57 The review team also proposed revised terms of reference for AMWAC, including:

- to provide advice to AHMAC on a range of medical workforce matters;

- to develop models for describing and predicting future medical workforce requirements and provide advice on its methodology, including indicators and benchmarks, for use by the employing and workforce controlling bodies including governments, specialist colleges and tertiary institutions;

- to oversee the establishment and development of data collections concerned with the medical workforce, and analyse and report on those data to assist workforce planning;

- to work in coordination and cooperation with the Australian Health Workforce Officials' Committee in the assessment of broader health human resources planning requirements;
- to provide AHMAC with advice as requested on best practice models of care, future service delivery developments and dynamic scenario planning for the medical workforce;
- to take information on evidence-based practice and outcomes into account in its planning and provide advice in this in its reports; and
- to advise AHMAC on possible approaches to achieving desirable workforce supply in accordance with quality health care practices.

Government response to AMWAC review

7.58 At its May 2002 meeting, AHMAC accepted the recommendations contained in the final report entitled *Tomorrow's Doctors – Review of the Australian Medical Workforce Advisory Committee.*

8. THE IMPLEMENTATION OF AMWAC TARGETS – ROLE OF STATE AND TERRITORY GOVERNMENTS

8.1 As noted in previous chapters, surgical training in Australia occurs largely in public hospitals. There are three major requirements for establishing a surgical training position in the Australian public health system:

- the provision of sufficient state and territory government funding;

  In its submission following the draft determination, the Australian Health Ministers' Conference (AHMC) submitted that:

  > The numbers of medical specialists and training places are inextricably linked to the investment that Australian governments make in health services. Governments, as the principal funders and providers of the health system, thus play a key role in determining the amount of medical specialist training. This essentially occurs through AHMAC's consideration, and acceptance or otherwise, of AMWAC recommendations. Once AHMAC and Health Ministers have agreed on the number of training places required, there is an obligation on the specialist colleges and governments to implement the AHMC decision.[146]

- the agreement of the relevant medical college to accredit the training position or training program. This process is discussed in Chapter 6; and

- the establishment of the position in the hospital or other training institution.

Funding of surgical training positions

8.2 The establishment of surgical training positions in public hospitals requires not only funding for the salary of the trainee plus on-costs, but also sufficient funding to ensure that the College's accreditation criteria are met generally; for example, as regards advanced surgical training positions, that the public hospital provides:

- an appropriate case load and case mix (ie of patients);
- an adequate laboratory service;
- access to an appropriate number of autopsies;
- access to appropriate information technology equipment;
- an adequate diagnostic radiology department;
- an emergency accident service with 24 hours resident medical officer cover;
- a comprehensive outpatient clinic;
- adequate personal operative experience for the trainee under surgical supervision; and

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[146]The AHMC submission to the Commission, 22 June 2003, p3.

- a medical reference library.

8.3 The Minister for Health in Western Australia, the Hon Bob Kucera APM MLA estimated that approximately $100 000 per annum is necessary to cover a trainees' salary and on-costs.[147] Queensland Health estimated that funding of approximately $97 000 plus 23 per cent for on-costs is required for salaries of a new training position. Queensland Health further noted other costs such as additional infrastructure, equipment, nursing and allied health may add significantly to this cost. Queensland Health estimated that the total costs could be in the vicinity of $1 000 000 to $2 000 000 depending on the sub-speciality.[148]

Sources of funding

8.4 Each state and territory government provides around 50 per cent of public hospital funding in their state or territory, with the Commonwealth providing the other 50 per cent.[149]

8.5 Commonwealth funding is provided to the states and territories specifically for public hospitals in accordance with Australian Health Care Agreements between the Commonwealth and each state and territory. Current agreements run from 1 July 1998 to 30 June 2003.

8.6 The Agreements are built upon the Health Care Agreement Principles, which are enshrined in the *Health Care (Appropriation) Act 1998*. These principles are that public hospital services must be provided free of charge to public patients, that access to these services must be on the basis of clinical need and within a clinically appropriate period, and that people should have equitable access to public hospital services regardless of their geographical location.

Allocation of funding by states and territories to medical training posts in public hospitals

8.7 In almost all states and territories, it appears that funding for medical training posts in public hospitals is drawn from general budget allocations to public hospitals (or area health services); that is, no specific funding is provided for medical training posts.

8.8 NSW Health submitted that:

> Funding for [surgical training] positions is usually drawn from the general hospital budget. There is no special purpose grant for funding of surgical training positions in NSW apart from some special purpose funding for some rural training posts.[150]

8.9 Queensland Health advised that funding for new and existing training posts is drawn by public hospitals from their general budget allocations.[151] The Commission understands that Queensland public hospitals are formally part of Queensland Health. Consequently, their budget allocation is part of Queensland Health's budget allocation.

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[147] Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submission to the Commission, 18 September 2002.
[148] Queensland Health submission to the Commission, 24 September 2001, p1.
[149] *Health Expenditure Australia, 2000-01*, Australian Institute of Health and Welfare, September 2002, p2.
[150] NSW Health submission to the Commission, April 2002, p7.
[151] Queensland Health submission to the Commission, 24 September 2001, p2.

8.10 The Health Department of Western Australia advised that funding for training positions is drawn by hospitals from the allocation from their general budget allocation, with no specific allocation for training positions.[152]

8.11 The Tasmanian Department of Human Services submitted that:

> The Department has a global budget allocation, and the final determination of the number, location and funding of new training posts does not normally involve specific consideration of the case by the Minister or Government.[153]

8.12 The ACT Department of Health, Housing and Community care advised that it does not provide funding specifically for new training posts. Training programs are filled from the budgets of the relevant clinical departments within ACT hospitals. A proportion of these funds is allocated to training and development, but it is for the hospital to determine what types of training and development this funding is allocated to. The Department noted that levels of actual spending on training and development are difficult to determine as much of the spending is interwoven with other hospital activities.[154]

8.13 On the other hand, the Victorian Minister for Health, the Hon John Thwaites MP, submitted that:

> Medical specialist training is heavily subsidised by State training and development grant funding (currently totally approximately $36m per annum) paid to public hospitals for trainee and clinical academic positions. State training and development funding however does not fund all accredited vocational training positions around the state, and where such funding is provided, it is a contribution to salary costs (ranging from 75% of base salary for Hospital Medical Officers Year 6, when vocational training commences, to 54% of base salary for Registrars). The total number of positions attracting the central subsidy is generally guided by recommendations on training numbers provided AMWAC.
>
> Hospitals, in consultation with medical staff and consultants can and do provide vocational training positions beyond those that attract the central subsidy. The salaries for these positions are funded from the hospitals' general revenue streams and would be based on an assessment that there was sufficient workload to sustain additional positions. [155]

8.14 The Victorian Department of Human Services added that:

> it seeks to provide the state-wide public hospital system with funding for a number of surgical trainee posts in observance of the recommendations of AMWAC.[156]

Implementing AMWAC targets

8.15 The Victorian Minister for Health, the Hon John Thwaites MP, submitted that in Victoria

> the establishment and accreditation of training positions is a matter of direct negotiation between the colleges and each hospital.[157]

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[152]Health Department of Western Australia, verbal submission to the Commission, 30 August 2001.
[153]Tasmanian Department of Human Services submission to the Commission, 27 August 2001, p2.
[154]ACT Department of Health, Housing and Community Care verbal submission to the Commission, 13 September 2001, p2.
[155]Victorian Minister for Health, the Hon John Thwaites MP, submission to the Commission, 30 September 2002, pp1,2.
[156]Victorian Department of Human Services submission to the Commission, 18 January 2002 p1.

8.16 Mr Thwaites also submitted that:

> The state plays a substantial role in funding and, increasingly, in planning medical specialist training positions. In relation to medical workforce planning, as well as facilitating implementation of AMWAC recommendations, Victoria is undertaking state based workforce planning studies to identify and respond to issues including supply and distribution.[158]

8.17 NSW Health submitted that in NSW the accreditation process can be summarised as follows:

- Advanced surgical training positions are usually initially established as "unaccredited" (service) positions.
- A decision is made locally to apply for accreditation where the hospital considers that there is a good prospect of achieving accreditation.
- The accreditation process requires extensive documentation and a formal survey. The documentation is prepared with input from the relevant Department of Surgery, the hospital administration and the Area Health Service.
- The total number of surgical positions (accredited and unaccredited) is determined by the area health service.[159]

8.18 Queensland Health submitted that:

> The identification of new training posts is the responsibility of the Department in consultation with individual hospitals. This is a top down bottom up approach whereby Hospitals/Department Heads/College representatives will at times initiate the creation of training positions in some specialities.
>
> New training posts are identified using AMWAC benchmarks and service needs.
>
> On identifying a need for a training position, the Department (usually the hospital Medical Superintendent) would ask the College to undertake an accreditation visit.[160]

8.19 Queensland Health further submitted that:

> funding is inextricably linked to accreditation of training posts. There is no point, for example, providing funding for a training post if accreditation cannot be obtained.[161]

8.20 The Commission understands that 'funding' in this statement refers to salaries and on-costs.

8.21 The Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submitted that

> potential higher surgical training [HST] posts may be identified by a hospital or health service or alternatively by the RACS. Hospitals or health services that consider they have the capacity to support a HST post are able to submit an application to RACS for an accredited training post. The RACS may

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[157]Victorian Minister for Health, the Hon John Thwaites MP, submission to the Commission, 30 September 2002 p2.
[158]Ibid, p1.
[159]NSW Health submission to the Commission, April 2002, p7.
[160]Queensland Health submission to the Commission, 24 September 2001, p1.
[161]Queensland Health submission to the Commission, 4 May 2001, p4.

if they consider a hospital or health service to have the capacity to support a HST post, initiate contact with this organisation to lobby for additional training posts. [162]

8.22 Mr Kucera also submitted that:

the number of trainees throughout Australia and in each state and territory is determined by AMWAC. On the basis of this information, the RACS identifies suitable training posts. The Department of Health then has to determine whether there are sufficient funds available within the state health budget to meet the cost of these posts.[163]

8.23 Again, the Commission understands that the reference to the 'cost' of training posts is a reference to salaries and on-costs.

8.24 The Tasmanian Department of Health and Human Services submitted that:

the hospitals which are engaged in specialist training in various disciplines are primarily responsible for identifying potential new training posts. Those hospitals are directly responsible to the Department's Director Hospitals and Ambulance, through the hospital CEO. There are no hospital boards or area health services. In practical terms, there is no distinction between the terminology 'department' or 'hospitals'.

A decision to identify a new training post is therefore a joint decision of the Department's Hospitals and Ambulance Service Executive Committee and both need and cost considerations are important factors in reaching the decision.

The Tasmanian section of the relevant college would also normally be consulted in identifying and requesting approval for a new training post.

Cost considerations, in particular the salary and on-costs of training posts, but also related infrastructure costs, are of fundamental importance in deciding whether a new training post will be established. An AMWAC recommendation for a new training post also has a very strong influence on the relative merits of that proposed post against other possible training or service influenced posts.[164]

8.25 The ACT Department of Health, Housing and Community Care advised that responsibility for identifying new training posts in the ACT rests with individual hospitals – specifically, clinical departments within hospitals identify potential training posts.[165]

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[162]Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submission to the Commission, 18 September 2002, p1.
[163]Ibid, p2.
[164]Tasmanian Department of Human Services submission to the Commission, 27 August 2001, p2.
[165]ACT Department of Health, Housing and Community Care verbal submission to the Commission, 13 September 2001, p1.

9. PUBLIC BENEFIT TEST

9.1 The Act provides that the Commission may only grant authorisation where the public benefit test in section 90 of the Act is satisfied.

9.2 While section 90 contains three minor variations of the public benefit test, the Commission adopts the view taken by the Trade Practices Tribunal (now the Australian Competition Tribunal) that in practice the tests are essentially the same.[166]

9.3 In this case, the College has applied under sub-section 88(1) of the Act and the Competition Codes of each state and territory to give effect to arrangements that have the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

9.4 The relevant formulation of the public test is therefore found in sub-section 90(7) of the Act, which provides that the Commission shall not grant such an application unless it is satisfied in all the circumstances:

- that the arrangement has resulted, or is likely to result, in a benefit to the public (the public benefit); and
- that this benefit outweighs or would outweigh the detriment to the public constituted by any lessening of competition that has resulted, or is likely to result, from giving effect to the arrangements (the anti-competitive detriment).

9.5 The Commission therefore must examine the likely public detriment from any anti-competitive effect of the arrangements as well as the likely benefit to the public arising from the arrangements. Should the likely benefit outweigh the likely anti-competitive detriment, the Commission may grant authorisation. If not, the authorisation may be denied. However, section 91(3) of the Act allows the Commission to grant authorisation subject to conditions that ensure that the public benefit outweighs the anti-competitive detriment.

Definition of public benefit and anti-competitive detriment

9.6 Public benefit is not defined by the Act. However, the Australian Competition Tribunal has stated that the term should be given its widest possible meaning. In particular, it includes:

> anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements ... the achievement of the economic goals of efficiency and progress.[167]

9.7 Similarly, anti-competitive detriment is not defined in the Act but the Tribunal has given the concept a wide ambit. It has stated that the detriment to the public constituted by a lessening of competition includes:

> any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency...[168]

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[166] *Re Media Council of Australia (No. 2)(1987) ATPR 40–774 at 48,419.*
[167] *Victorian Newsagency (1994) ATPR 41–357 at 42,677.*
[168] *Victorian Newsagency*(1994) ATPR 41–357 at 42,683.

Future with-and-without test

9.8 The Commission also uses the 'future with-and-without test' established by the Australian Competition Tribunal to identify and measure the public benefit and anti-competitive detriment generated by arrangements proposed to be authorised.[169]

9.9 Under this test, the Commission compares the public benefit and anti-competitive detriment likely to be generated by arrangements in the future if the authorisation is granted with those generated if the authorisation is not granted. This requires the Commission to make a reasonable forecast about how the relevant markets will react if authorisation is not granted. This forecast is referred to as the counterfactual.

Market evaluation

9.10 The Commission identifies and measures the public benefit and anti-competitive detriment generated by arrangements for which authorisation is sought in the relevant markets. This requires the relevant markets to be defined.

9.11 Section 4E of the Trade Practices Act states that a market for goods or services includes other goods or services that are substitutable for, or otherwise competitive with, the first goods or services.

9.12 In establishing a market's boundaries, the Commission seeks to include:

- all those sources of the product or closely substitutable products to which consumers would turn in the event that the firms currently supplying them attempt to raise the price of the product; and
- all potential consumers of a product to which suppliers would turn if they cannot obtain an adequate price for this product from their current consumers, as well as all consumers of products suppliers can readily supply in place of this product.

9.13 The Commission may define up to four different dimensions of a market. These are:

- the geographic dimension – this may be local, state, national or international depending on where trade occurs;
- the product dimension – this will depend on whether products are close substitutes for one another;
- the functional dimension – this requires, where relevant, the identification of appropriate stages of production and distribution (for example, the delineation of retail and wholesale markets); and
- the time dimension – where relevant, this refers to the time period over which substitution possibilities should be considered.

9.14 Generally, if market boundaries are defined to narrowly so that actual or potential sources of competition are excluded then the proposed conduct will appear to generate greater anti-competitive detriment than is actually the case. On the other hand, the market may be defined too widely to, for example, include, inappropriately, certain

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[169] See, for example, *Re Australasian Performing Rights Association* (1999) ATPR 41-701.

products or geographic areas. In such circumstances the anti-competitive detriment of the proposed conduct will appear to be weaker than it actually is.

9.15 Depending on the circumstances, the Commission may not need to comprehensively define the relevant markets to undertake a public benefit analysis. In particular, it may not need to precisely delineate or delineate at all one or more of the four market dimensions. For example, it may be apparent that a net public benefit will or will not arise regardless of this definition. Therefore, in the authorisation context, it is only necessary for the Commission to delineate the relevant market to the extent needed to asses the public benefits and detriments of the proposed conduct.

Whether arrangements breach the Act

9.16 As indicated above, the College's application seeks to give effect to arrangements which have the purpose, or have or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

9.17 However, in assessing an application for authorisation, the Commission is not required to form a view about whether the College's arrangements breach section 45. It is only required to determine whether the public benefit test has been satisfied.

Term of authorisation

9.18 Section 91(1) of the Act allows the Commission to grant authorisation for a specific period of time. The Commission's usual practice is to make use of this provision so as to provide it with an opportunity to review authorisations in the light of any changed circumstances. The period for which the Commission grants authorisation will depend on the specific circumstances of each case.

9.19 The Commission may also authorise different aspects of conduct for which authorisation is sought for different periods.[170]

[170] *Re 7-Eleven Stores Pty Ltd* (1998) ATPR 41-666.

10. THE COLLEGE'S SUPPORTING SUBMISSION[171]

Public Benefits

10.1 The College argues that the arrangements for which authorisation is sought produce the following public benefits.

Maintenance of high standards of surgical practice, the protection of public health and safety and the maintenance of public confidence

10.2 The College contends that it conducts a comprehensive selection, training, examination, accreditation and assessment program in order to maintain high standards of surgical services which in turn ensures that trainees become safe and competent surgeons. The comprehensive nature of the arrangements protects public health and safety and maintains public confidence in surgical services as well as the health care industry as a whole.

10.3 The College states that all of its programs are up-dated and enhanced to take account of international developments and to ensure they accord with 'international best practice.' Further, the high standards of surgical practice in Australasia are recognised in the international community.

10.4 The College argues its reputation and standing, and the continuation of its work is also a public benefit as it ensures that surgeons will continue to be trained to the highest standards.

10.5 In particular, the College contends that the rationale behind the comprehensive accreditation process in place for the basic and advanced surgical training programs is that:

- it is crucial for maintaining high standards of surgical services to ensure that hospital posts are sufficiently and appropriately supported and supervised so trainees can receive comprehensive training and guidance; and
- several posts are required to obtain sufficiently wide experience.

10.6 The College further contends that it is essential that there is a consistently high standard amongst all doctors, both locally and overseas trained. Consequently, there must also be a comprehensive assessment procedure for overseas trained practitioners.

Economic efficiency and cost savings to the public

10.7 The College noted that, given Australia's ageing population, it is especially important that high standards of surgical services are maintained at the lowest possible cost to the public because:

- the demands of the elderly on health care systems are much greater than those of the young; and

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[171] This chapter is taken from the College's submission, 14 May 2001.

- an ageing population increases the ratio of the number of people outside the labour force to those inside it.

10.8 In a predominantly tax funded health care system, such as Australia's, these two factors means that a declining proportion of the population is contributing to the costs of health care, even as those costs are rising.

10.9 The College contends that it makes a significant contribution to containing health care costs because:

- it is a non-profit organisation; and
- does not receive any government funding directly for selection, training, examination, accreditation, education and continuing professional development.

10.10 It adds that the only costs incurred by the public from the College's activities are generated through government funding of hospital posts and the administration of rural training schemes.

Pro bono services

10.11 The College argues that its Fellows supply their services to the selection, training and examination programs free of charge (while trainees do pay fees, these cover administrative, educational development, examination etc costs).

10.12 The College estimates that, conservatively, this pro-bono work by Fellows saves the community a minimum of $230 million per annum, excluding capital costs of some $70 million associated with conducting the College's programs. Table 10.1 sets out how the College has calculated this estimate.

Table 10.1: calculation of the value of the College's pro-bono work[172]	
RECURRENT COSTS – EDUCATION AND TRAINING	
Skills course	
1. Fellows time – EMST 441 000 – CCrISP 756 000 – BSS 378 000	1 575 000
2. Equipment (donations)	50 000
3. Administration and Capital (refer below)	
Training and Supervision of Trainees	
1. Fellows time (1500 trainees x 30 hrs supervision per week x 48 weeks x $100 per hour)	216 000 000
2. Administration and Capital (refer below)	
Examinations	

[172] The College's submission to the Commission, 30 March 2001, Attachment 11.

1. Fellows time Part 1 Exam: MCQ (6 days x 30 Fellows x $1500 per day) OSCE (6 days x 120 Fellows x $1500 per day) Part 2: (7 days x 135 Fellows x $1500 per day) 2. Administration and capital (refer below)	 270 000 1 080 000 1 417 500
Overseas trained doctor assessments 1. Fellows time (80 applications x 2 days x $1500 per day) 2. Administration and capital (refer below)	 240 000
Curriculum materials development 1. Contracts (Distance Learning Program) 2. Fellows time (22 modules x 5 days x $1500)	 750 000 495 000
Educational Committees (CIC Committee, Speciality Boards, Board of CPD) 1. Fellows time (3 days x 150 Fellows x $1500 per day) 2. Administration and capital (refer below)	 675 000
RECURRENT COSTS – INFRASTRUCTURE **Operational budget** (Total College budget - $14m) Salaries Consumables Travel and accommodation Utilities Minor equipment	 10 500 000
TOTAL	**232 782 500**

10.13 In calculating this, the College states that only costs which are directly attributable to the education and training programs of the College have been taken into account. The College also notes that the hourly rate used to calculate the value of the training provided by surgeons – $100 – is likely to be lower than the market rate that would be charged by surgeons for their services, particularly given that the more experienced and senior surgeons tend to provide training.

10.14 The College adds that beyond the costs savings and the amount of time spent by a fellow with a trainee is the patience, tolerance and skill required to train surgical trainees. The College states that while some training takes place in low risk environments, for example, through the use of simulators, Fellows must also be vigilant and attentive to trainees in order to ensure early error recognition and recovery.

Consequence of the College ceasing the conduct sought to be authorised

10.15 The College states that currently it is the sole body in Australasia training surgeons in the nine surgical sub-specialties. It argues that, if it were to cease undertaking the arrangements for which authorisation is sought, a new entity (or entities) would have to be created to undertake them. This new entity would need to develop programs to ensure the same high standard of surgical service is maintained.

10.16 The College argues that this new entity would need to recruit qualified surgeons, as the skills and attributes of a safe and competent surgeon can only be learned by a trainee watching, participating and progressively doing what a surgeon does under the tuition of other surgeons.

10.17 The College contends that surgeons may choose not to become involved in training if they were paid to provide it, as introducing payments would undermine the professional ethos that surgeons consider underpins their training of surgical registrars. Ultimately, the cost to the taxpayer of the new entity would equal the value of the pro-bono work provided by surgeons under the current system – that is, at least $230 million per annum.

10.18 The College adds that it is not only the cost but the time and effort required, the dislocation of training new surgeons and the uncertain effectiveness of any new system which must be taken into account.

10.19 The College concludes that establishing a new system is clearly not the most efficient use of society's resources.

Other public benefits

10.20 The College argued that its activities more generally give rise to many public benefits. For, example, the College provides for the ongoing retraining and professional development of Fellows through its continuing professional development program. The College and its Fellows also continue to work free of charge on a number of public safety and health initiatives as well as running outreach programs delivering essential surgical services to remote areas within Australian as well as overseas.

Anti competitive detriment

10.21 The College contends that it has no ability to limit the number of persons entering the surgical profession. It is only able to select and train as many suitably qualified doctors as there are funded and accredited posts in hospitals. It aims to fill all such training posts.

10.22 The College states that decisions to fund hospital training posts are made by state and territory governments and by hospitals. It adds that, in special circumstances, the Federal Government may also have a significant role (e.g. by funding rural posts). The College states that in 2001 it identified five orthopaedic posts for accreditation that were not eventually funded.

10.23 While the College accredits training posts, it does this to ensure hospitals meet training requirements and educational standards.

10.24 The College states that shortages of hospital beds and reduced theatre schedules

hamper its ability to train surgeons. It notes that, in his report into surgical services in Australia (see paragraph 1.23), Professor Peter Baume found that shortages in hospital facilities and services impact directly and immediately upon the capacity of surgeons to train other surgeons.

10.25 For example, the College understands that at Monash Medical Centre there is a waiting list of 2500 orthopaedic patients. There are 15 orthopaedic surgeons, but they are under-employed because reduced theatre schedules mean that available operating theatre hours are exhausted by emergency cases or non-elective surgery.

10.26 The College contends that while surgeons in a large capital city can probably find work in other hospitals, in rural areas, such as Lismore, the same lack of beds and operating theatres has led to surgeons to leave the area. The College argues that if the number of surgeons falls, the hospital may no longer be suitable as a training centre and this in turn has an impact on trainee numbers in particular sub-specialties.

10.27 The College argues that its role in relation to the placing of overseas trained practitioners is a recommendatory one only, and that decision-makers do not have to follow the College's recommendations.

10.28 The College states that it receives approximately 100 applications a year and almost all applicants ultimately receive a recommendation. The range of possible recommendations is set out at paragraph 6.121.

10.29 The College states that:

- the absolute limit on candidates for surgical training is the number of entrants to medical school;
- the Commonwealth government's limitation on the number of Medicare provider numbers awarded to medical graduates further reduces the number of potential trainees as a trainee cannot be awarded a post without a provider number;
- it is not always able to fill all available posts because not every doctor wishes to pursue a career in a particular specialty. For example, in 2001 the College was unable to fill all available neurosurgery posts because not enough suitably qualified people applied; and
- the number of training places is influenced by AMWAC recommendations to health ministers. The College notes that the number of surgeons it trains is substantially similar to the number recommended by AMWAC.

Conclusion

10.30 The College concludes that the arrangements for which it seeks authorisation confer extensive and significant public benefits which outweigh any possible anti-competitive detriment. It also re-affirms its view that none of its activities raise concerns under the Act.

Other issues

The market for surgical services

(a) The product market

10.31 There are nine recognised surgical sub-specialties: general surgery; neurosurgery; otolaryngology – head and neck surgery; plastic and reconstructive surgery; vascular surgery; cardiothoracic surgery; orthopaedic surgery; paediatric surgery; and urology.

10.32 However, the College submits that the unique features of the surgical profession make it extremely difficult to define a market or series of markets. In particular, it submits that, rather than a series of separate markets for surgical sub-specialties, there are a series of sub-markets within the markets for surgical services. In particular, it highlights that:

- surgeons often choose, for personal interest reasons, to specialise in part of the specialty in which they were trained. Further, surgeons may change their area of sub-specialisation over time. Consequently, the skills of surgeons who notionally practise in the same specialty may not be substitutable;
- there are significant overlaps between different sub-specialties. For example, hand surgery can be performed by plastic and reconstructive surgeons, orthopaedic surgeons and general surgeons. Consequently, the skills of surgeons who are notionally in different sub-specialties may in some cases be substitutable; and
- the public perception is that the relevant market is one for surgery.

10.33 The College concludes that the relevant product markets are likely to be the markets for specialist surgical services and that, within each of these markets, there are a series of sub-markets where there is, in many cases, significant overlap at the margins.

(b) The geographical market

10.34 The College highlights that

- doctors are registered to practise in the state or territory in which they live and work;
- employment opportunities for surgeons are largely available on the basis of funding decisions made by state and territory governments and the relevant hospitals;
- patients will generally travel to the major metropolitan centres within each state to seek treatment;
- while there is been substantial movement of surgeons between states, particularly in their early years, this does not outweigh the factors above such that there is a national market.

10.35 Ultimately, the College submits that the relevant markets are the state-based markets for specialist surgeons.

Competition between surgeons

10.36 The College submits that there is significant competition between the surgeons in the various sub-specialties. At all times, however, surgeons are conscious of the ethical constraints they must work under.

10.37 The College highlighted that surgeons mainly compete with each other by gaining

strong professional reputations such that cases are referred to them.

10.38 The College does not have detailed information as to the price competition that may occur between surgeons. However, it submits that, given that human life is at stake or patients are concerned with the carrying out of operations that will give them a better quality of life, price competition is of less significance for surgeons than it may be in other professions.

10.39 However, the College states that, in private hospitals, surgeons generally charge within 15 per cent of the Medicare rebate and, to this extent, they compete on price. The College also notes that, as individual surgeons are likely to work in both the public and private hospital systems, they could be regarded as competing with themselves on price when surgeons accede to their patient's wish that they be treated in a public hospital.

Supplier-induced demand for medical services

10.40 The College has no firm view as to whether the theory of supplier-induced demand is correct.

10.41 The College also notes that government considers that a limitation on the number of doctors generally will generate cost savings. In particular, the College argues that the government, in making funding decisions, and AMWAC, in making recommendations, are influenced by the theory of supplier-induced demand. It notes that, in its *Report into the Health Insurance Amendment Bill (No 2) 1996*, the Senate Community Affairs Legislation Committee recognised that:

> There is widespread agreement that the increasing number of medical practitioners is one of the main growth pressures on the health costs in Australia.[173]

10.42 The College argues that the government's role in funding suitable hospital places and its approach to holding down costs by limiting the number of doctors, means that the College, subject to its lobbying efforts, can only train as many surgeons as there are places. The College stated that it is therefore arguable that public benefits, in terms of cost savings, maintaining the reputations of practitioners, and encouraging the best and brightest to pursue medical careers, are not generated by opening the surgical services market to anyone who may wish to pursue a career in surgery.

10.43 The College also argues that as Australia's health care sector is largely funded by Medicare, the normal constraints that the price of services place upon consumers' demand are distorted. With bulk billing readily available for many services, patients are able to 'doctor shop' at no cost to themselves and seek medical services which they may have otherwise foregone.

10.44 The College argues that this pricing distortion has led to the problem of over-servicing in some areas of the health care industry. It further contends that the pricing distortion in medical services must be taken into account in any economic analysis.

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[173]Senate Community Affairs Legislation Committee, *Report into the Health Insurance Amendment Bill (No 2) 1996* (November 1996) 6 found at: http://www.aph.gov.au/senate/committee/clac_ctte/insurance/hiab2.htm.

Market based approaches to the health care sector

10.45 The College submits that a strict market based approach is incompatible with both health care and the training of surgeons. Further, the market's operation cannot be paramount in an area of the economy that is concerned with matters of life and death.

10.46 The College agrees with the views of Paul Komesaroff, Director of the Eleanor Shaw Centre for the Study of Medicine, Society and Law at the Baker Medical Research Institute.[174] He argues that if the unrestrained operation of market forces is introduced into the training of surgeons (together with the assumption that financial considerations are paramount in all clinical decisions) then economic values will penetrate the heart of the medical relationship. If economic values are made paramount in the provision of health services, patients will suffer where previously they have been assured of disinterested and compassionate care from their health care providers. Such circumstances would also create great costs and difficulties for the community.

10.47 In particular, the College contends that arguments made in favour of increasing the role of the market in the health care sector are flawed because:

- the assumptions underlying these arguments are based upon a flawed view of human action and relationships. The College highlights Komesaroff's view[175] that it is wrong to assume that:
  - consumers of medicine always act out of self-interest, use their own money to buy all goods and services and seek the best price quantity/quality combination; and
  - providers are primarily concerned with their own interests, adapt their prices and throughput in the light of consumers' purchasing, act to maximise profits by increasing market share at acceptable prices and always seek to use labour and resources sparingly;
- the health care market contains distortions in pricing and in information. In particular, one of the primary reasons that the health care sector is different is that consumers are not in a position to make informed judgments about the services they need. The College contends that these judgements can only be made by trained professionals and are made independently of considerations of reward.

10.48 The College further argues the health care sector is clearly distinguishable from other sectors where pricing and advertising are often the primary consideration for purchasers because:

- most people do not acquire health care services on an ongoing basis, which reduces their ability to make appropriate choices;
- Medicare reduces the cost of the services of medical practitioners for consumers, with the consequence that they are likely to demand more of these services than if Medicare did not exist; and

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[174]Paul Komesaroff, 'Ethical implications of competition policy in health care' *Medical Journal of Australia* (1999) vol 170, 266-268 found at http://www.mja.com.au/public/issues/mar15/komesaroff/komesaroff.html.

[175]Ibid.

- most people cannot understand the complex health care field, their needs are immediate and decisions about their health need to be taken at times of emotional pressure.

10.49 The College states that it has instilled in surgical trainees the ideals that are necessary to assist members of the community when at their most vulnerable to make choices regarding their health and lives. The College is concerned that a move from the current system would reduce its ability to ensure that patients' interests are paramount;

- they fail to address concerns regarding the maintenance of standards; and
- they do not recognise and protect the non-quantifiable features of compassion and ethics that are inherent in the provision of medical services. The College contends that patients become dependent on doctors with whom they have established ongoing relationships of trust and who in turn are committed to their patients' interest and that such a relationship cannot be understood purely as a commercial relationship.

Length of authorisation

10.50 The College contends that no time limit should be placed on the authorisation it seeks because the public benefits it has claimed in support of its application will be assured through the AMC accreditation process (see paragraph 1.24).

11. SUBMISSIONS FROM INTERESTED PARTIES PRIOR TO THE DRAFT DETERMINATION

11.1 Upon receiving the College's application and supporting submission, the Commission invited a range of interested parties to comment on them.

11.2 The Commission received over 80 substantive submissions prior to the draft determination from, among others, state and territory health departments, state and territory medical registration boards, specialist medical colleges, industry associations, consumer groups, private health insurance funds and university medical faculties.

11.3 These submissions are summarised in the Commission's draft determination. Copies of all public submissions are also available from the Commission's Public Register. The submissions are, where relevant, reproduced in the evaluation chapters of this determination.

11.4 Broadly, the views of interested parties on the College's application provided before the draft determination was issued in February 2003 can be summarised as follows.

Government

11.5 Broadly, governments supported authorisation being granted provided concerns held by nearly all of them regarding transparency, accountability, fairness and consistency of the College's processes were addressed. The views of individual governments put to the Commission before the draft determination are reproduced at relevant points of the evaluation chapter (Chapter 13).

The Australian Medical Council

11.6 The Australian Medical Council (AMC) mainly focuses on the issue of overseas-trained specialists. The AMC submits that:

- 'there are significant variations in the training and professional experience of specialists [between countries]. In some cases, specialist training ... follow the pattern ... in countries such as Australia, the United Kingdom and Canada. In other countries, such as those in Eastern Europe, specialists may commence their advanced training during the last years of their basic medical course. The effect of these variations is that a large number of overseas-trained specialists will not be able to establish full equivalence with Australian trained specialists without additional training to cover aspects of specialist practice that were not part of their original specialist training or experience'; and

- 'if authorisation... is withheld, and the College (and possibly other specialist colleges) withdraw from the assessment process, it would represent a significant retrograde step. Such an outcome would remove an important avenue by which overseas-trained specialists can establish their eligibility for registration. The only alternative for many of these specialists would then be to attempt the AMC examination for general registration. In the absence of suitable re-training and bridging courses in Australia, this would represent a considerable hardship for

many overseas trained specialists...'; and

State medical boards

11.7 Those state medical boards which provided submissions (South Australia, Queensland and Western Australia) support the College's application for authorisation.

Medical schools

11.8 Medical schools generally supported the College's application for authorisation.

Specialist medical colleges

11.9 Specialist medical colleges supported the College's application for authorisation for similar reasons to those put forward by the College.

Medical Societies/Associations

11.10 Several medical societies and associations supported the College's application for similar reasons to those submitted by the College. These included the Australian Healthcare Association (the national industry association for the public hospital and healthcare sector), the Australian Medical Association (AMA) and the various surgical specialist societies (for example, the Australian Orthopaedic Association and the Urological Society of Australia).

Health funds and private hospital groups

11.11 A number of health funds and private hospitals expressed concerns about the College.

11.12 For example, Mayne Health expressed concern about the assessment of overseas-trained surgeons and the accreditation of hospital training positions. The Australian Health Insurance Association (AHIA) considered 'it doubtful [whether] authorisation should be granted' for the College's processes in hospital post accreditation or trainee approval. Calvary Health Care ACT (Calvary) submitted that the College should not specifically determine the number of trainees allowed into the training schemes or the number of trainees that could be employed by a specific hospital. If an approved hospital can fulfil the training requirements then that hospital should be free to determine the number of trainees it needs to employ.

Other

11.13 The Australian Consumers Association (the ACA) opposed authorisation of the College's arrangements. The Community Relations Commission for Multicultural NSW (CRC) did not support authorisation of the arrangements as they stood. The CRC's submission focuses on the processes for assessing overseas-trained practitioners. the Australian Doctors Trained Overseas Association (ADTOA) raised concerns about how overseas-trained surgeons are assessed.

12. ISSUES ARISING FROM THE DRAFT DETERMINATION

Pre-determination conference

12.1 Pursuant to section 90A of the Act, the Australian Consumers' Association requested that a pre-determination conference be held in relation to the draft determination. Subsequently, requests for a conference to be held were also made by the Western Australian Minister for Health, the Hon Bob Kucera and the Community Relations Commission of New South Wales.

12.2 The conference was held in Melbourne on 18 March 2003. A range of organisations were represented at the conference including the College, Commonwealth and state health departments, the Australian Consumers' Association, the Australian Medical Association, the Australian Medical Council, AMWAC, the Health Services Commission (Victoria), Australian Private Hospitals Association, Australian Doctors Trained Overseas Association and other specialist medical colleges. A record of conference proceedings is available from the Commission's Public Register.

Submissions

12.3 The Commission received around 30 public submissions in response to the draft determination. A list is at Attachment G. Copies of all non-confidential submissions are available on the Commission's Public Register. Submissions are reproduced where relevant in Chapter 13 of this determination.

12.4 Broadly, the College expressed strong concerns about the Commission's public detriment findings. However, it indicated that it could comply with most of the proposed conditions, subject to fine tuning in some cases. In addition, the College expressed substantive concerns about three conditions proposed in the draft determination, namely:

- the proposed review of its criteria for accrediting hospital posts;
- the proposed review of how it assesses overseas-trained surgeons; and
- the proposed reforms to its appeals processes.

12.5 The College also expressed strongly supported a longer authorisation period.

12.6 Generally, the AHMC supported the direction of the draft determination. However, it proposed some revisions to the detail of some of the conditions of authorisation proposed by the Commission. In addition, the AHMC proposed two new conditions of authorisation, including the College establishing memoranda of understanding (MOUs) with health ministers to give effect to the terms of the relevant conditions proposed by the Commission.

Other interested parties

12.7 The Commission received a number of submissions from interested parties expressing support for the direction of the draft determination including from Catholic Health Australia, the Health Consumers' Council (WA), Health Care Complaints

Commission (NSW) and the Health Complaints Commissioner (Tasmania).

12.8 The Australian Consumers' Association, while supporting the proposed reforms, did not consider they went far enough. The Australian Private Hospitals Association, while supporting the proposed reforms, proposed that reforms be imposed to facilitate surgical training in private hospitals.

12.9 The Hunter Area Health Service (NSW) submitted that it, in conjunction with the University of Newcastle and possibly the College, proposed to establish a new training program based in the Hunter Valley.

12.10 Dr Mark Shanahan commented on a range of issues relevant to the College. Generally, he supported the College but considered that there was room for improvement, particularly in relation to its assessment of overseas-trained surgeons. For example, he considered that the appropriate test for assessing overseas-trained surgeons should be whether they are competent, and that:

> ...the community should accept the good and not so good surgeons. It's only the bad surgeons we must eliminate.[176]

12.11 Dr Shanahan also highlighted that sensitivity to cultural differences is essential when interviewing applicants for surgical training. For example, it may take overseas-trained surgeons from non-English speaking countries longer to interpret questions and formulate the appropriate response in English.[177]

12.12 Dr Shanahan also noted submitted that if the College requires overseas-trained surgeons to undertake further training, it must ensure that training posts are available for these trainees.[178]

12.13 He also considered that some of the proposed reforms may be cumbersome and costly to implement and suggested focusing on the College's appeals process.[179]

12.14 The Community Relations Commission of New South Wales, the Anti Discrimination Board of NSW and the Australian Doctors Trained Overseas Association (ADTOA) broadly supported the proposed reforms, particularly as they relate to overseas-trained surgeons. However, ADTOA considered that they had not gone far enough.

12.15 Some interested parties did not indicate whether they supported the draft determination but commented on particular issues; for example, the University of Sydney, the University of Queensland and the Royal Australian College of General Practitioners.

12.16 The Australian Medical Association supported the College's response to the draft determination.

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[176]Submission from Dr Mark Shanahan, 13 March 2003, p2.
[177]Ibid.
[178]Ibid, p3.
[179]Ibid, p5.

13. EVALUATION

Introduction

13.1 A fundamental consideration underlying the Commission's approach to the College's application for authorisation is that surgical training is an essential service. It is self-evidently impractical for Australia to rely on overseas-surgical training programs to supply sufficient surgeons to meet Australian patients' needs – a local surgical training system is clearly required. Similarly, there needs to be a process for assessing the competence of overseas-trained surgeons who wish to practice in Australia.

13.2 Currently, the College administers Australia's surgical training system and plays the key role in assessing overseas-trained surgeons. This is essentially an accident of history (see Chapter 4) and alternative systems are conceivable that would avoid some of the disadvantages of relying on the College. Possible alternative systems are discussed further at paragraphs 13.15 to 13.33.

13.3 Having said this, moving to an alternative system would require the support of Commonwealth, state and territory governments.

Submissions from health ministers before draft determination

13.4 The Commission significantly extended the public consultation period for the College's application prior to issuing a draft determination to provide an opportunity for governments to lodge submissions. Ultimately, the Commission received submissions from most health ministers.

13.5 Health ministers supported the continuation of the College's surgical training program, although many expressed concerns about particular aspects of the College's processes which they wished to see addressed before any authorisation was granted. The broad view of each government was as follows.

13.6 The Commonwealth supported granting authorisation. It considered that there was no alternative body available to take over the processes for which the College has sought authorisation. It also submitted that:

> while acknowledging that there have been aspects of trainee selection and assessment procedures by a number of specialist medical colleges in the past that gave cause for concern (and some that are still being worked through), we have been pleased to note substantial progress in recent years by all specialist colleges in implementing recommendations of the Brennan report (in relation to trainee selection) and the Australian Medical Workforce Advisory Committee (in relation to numbers of specialist training positions). The Australian Medical Council and the Committee of Presidents of Medical Colleges have also been working together to develop improved processes for assessment of overseas-trained doctors. Much of the progress made in workforce planning and policy has been at the instigation of the Department. We are, of course, well aware of areas of concern in the workforce and have been moving steadily towards rectifying these – with the co-operation of the specialist colleges, including the College.[180]

[180]Commonwealth Department of Health and Ageing submission, June 2001, p4.

13.7 NSW supported granting authorisation as long as its concerns – in particular, relating to the transparency and accountability of the College's processes for accrediting hospital posts, assessing overseas-trained trained practitioners and selecting surgical trainees – were addressed.[181]

13.8 Victoria supported granting authorisation. It submitted that:

> while existing processes may well be soundly based, increased transparency regarding the criteria and processes for decision-making is desirable.[182]

13.9 Queensland:

> accepts that there is an overwhelming public benefit that derives from the activities of the specialist colleges such as the RACS in setting, developing and maintaining medical standards. It cannot accept that there is any public benefit in these activities occurring without being demonstrably fair, consistent transparent and non-discriminatory...
>
> It is essential that the Colleges continue to develop transparent, valid and reliable processes subject to effective appeal mechanisms and external accountability to government and the Australian Medical Council. The Colleges will have little to fear from bodies such as the ACCC if these processes are in place.[183]

13.10 South Australia:

> is of the view that the RACS has not yet recognised the need to consult and engage the employer responsible for the funding and provision of public health services and, in particular, to assist it in addressing areas of need. Therefore it is not, in my view, ready to be granted the authorisation *as requested* [emphasis added].[184]

13.11 Given the reference to not granting authorisation 'as requested', the Commission interpreted South Australia's view as being broadly similar to that of NSW, Victoria and Queensland.

13.12 Western Australia highlighted that:

> the community would not accept the proposition that the government is not accountable for the availability of adequate acute specialist surgical services in the public hospital system, not to say the available of specialist surgical services generally. In reality, therefore this is not a responsibility the government can leave to an independent non-government body without adequate safeguards...
>
> Western Australia is concerned about the apparent limitations in the accountability arrangements and transparency in the way RACS performs their essential function of training and maintaining an adequate medical specialist workforce...
>
> Western Australia has not seen convincing evidence that justifies a hands off approach to the oversight and regulation of the processes required to ensure the supply of sufficient numbers of specialist surgeons.[185]

13.13 Again, the Commission interpreted Western Australia's view to be that it would support authorisation as long as its concerns about the accountability and transparency of the College, and about its ability to determine where training posts are located (subject to accreditation requirements), were addressed.

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[181]NSW Health submission, April 2002, p4
[182]Submission from Victorian Minister for Health, the Hon John Thwaites, 3 October 2002, p1.
[183]Submission from Queensland Minister for Health, the Hon Wendy Edmond, 25 September 2002, p3.
[184]Submission from South Australian Minister for Health, the Hon Lea Stevens, 11 September 2002, p2.
[185]Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p2.

13.14 The Australian Capital Territory submitted that the:

> strong influence of the College [over surgical training numbers] highlights the need for certain assurances to be undertaken by the College before the ACT government could support the Royal Australasian College of Surgeons' application for authorisation.[186]

Submissions in response to the draft determination

13.15 The AHMC submitted that it:

> recognise[s] that currently the College is the only body with the capacity and expertise to provide surgical training and specialist assessment of overseas-trained surgeons, and acknowledge that the College will continue in this role.[187]

13.16 However, the AHMC also submitted that:

> the accreditation of alternative providers of specialist training is possible through the accreditation processes of the Australian Medical Council.
>
> Since the draft authorisation was published, a number of universities have indicated an interest in the provision of surgical training. Health Ministers acknowledge that alternative training for surgeons may develop in collaboration with the College or otherwise.[188]

13.17 The Hunter Area Health Service, based in Newcastle, New South Wales:[189]

> strongly advocates new and immediate solutions to address the medical workforce crisis in outer-metropolitan, regional and rural communities...
>
> there is now an independent body [the Australian Medical Council] able to accredit a non-College organisation wishing to provide postgraduate specialist training...
>
> until recently, the Royal Australian College of General Practitioners (RACGP) was the sole provider of postgraduate training for general practitioners. However, training has now been devolved to local providers... Some of these training consortia are university-based and in many the RACGP is a partner... There is now, therefore a precedent for postgraduate training being provided other than by a specialist college.
>
> The Commonwealth Government is now funding medical undergraduate students to have some, or the majority of, their training based in rural areas. This is evidence that training in a particular area makes a student much more likely to stay and work in the area after graduation.[190]

13.18 In particular, Hunter Health considers that:

> an opportunity now exists to establish a new, innovative, high-quality medical graduate training program – to be accredited by the Australian Medical Council and to complement the training program undertaken by the Colleges... For example, a surgical training program could be designed and implemented by the University of Newcastle, in partnership with the College and Hunter Health. Such a program could also stand-alone (without the College's involvement, if the College were not prepared to participate) and be independently accredited by the AMC...

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[186] Submission from ACT Minister for Health, the Hon Jon Stanhope, 23 October 2002, p1.
[187] AHMC submission, 25 June 2003, p1.
[188] Ibid, pp1-2.
[189] Hunter Area Health services a population of 550,000 based on Newcastle and the Hunter Valley, with a further 200,000 people in northern New South Wales relying on Newcastle as a referral centre of tertiary services.
[190] Hunter Area Health Service submission, 30 May 2003, pp6-7.

we have good evidence to suggest it is possible to establish a viable, high quality surgical training and assessment program on a "user-pays" system using existing resources, without the addition of government funding.[191]

13.19 Hunter Health considered that the benefits of establishing a complementary training program to those of the College would include:

fostering a stronger medical workforce in outer-metropolitan, regional, rural and remote areas; providing a diversity of quality, accredited training options for our medical workforce; [and] ensuring the future health service provisions required for our growing and ageing population are matched by an adequate and appropriately allocated medical workforce.[192]

13.20 Hunter Health further submitted that a new training program could also be used to assess the competency of overseas-trained surgeons.[193]

13.21 The University of Sydney submitted that:

the fact that university staff have a great deal to offer the Colleges is not acknowledged by government through the allocation of funds to universities with medical schools; consequently, medical schools do not have the resources for this particular task.

Nonetheless, there has been increasing collaboration between the universities and the College, notably with the implementation of basic surgical training programs and in proposals to base surgical skills centres in university settings. This clearly could all change with dedicated funding provided to the universities to establish surgical training programs, witness the university response to funding provided to increase rural training.[194]

13.22 The University of Queensland submitted that:

the College has established an excellent training program for surgeons with standards that are the envy of many countries around the world. That is not to say that they could not be improved or that alternative pathways for training would not produce a product of similar standard...

There are clearly opportunities for the universities and the state health systems to work together (with the Royal College) to create and accredit new training posts or (and this would not be a favoured option) set up an alternative training scheme.[195]

13.23 The University of Queensland further suggested how a specialist training program organised by universities and health departments might work. Broadly:

- posts in such a program would be accredited in the same way as posts in the College's program, possibly by an alternative accreditation organisation but preferably by the College;
- university staff would provide the clinical teaching (as many do already in their work in public and private hospitals);
- universities could offer specific surgical courses in particular areas, which could be combined with opportunities to pursue professional doctorates. The relevant medical colleges could be asked to accredit the learning modules provided in these professional doctorates as part fulfilment of specialist training;

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[191]Ibid, p7.
[192]Ibid, p8.
[193]Ibid.
[194]University of Sydney submission, 17 April 2003, p2.
[195]University of Queensland submission, 27 May 2003, p1.

- specialist colleges could continue to assess trainees in the same way each does now (for example, the RACS conducts an exit exam); and
- universities could also develop training programs with private hospitals.[196]

13.24 The College:

> accepts that universities may wish to establish their own training systems at some stage in the future. However, the College notes that establishing and running a training system for surgeons is extremely difficult and resource intensive...
>
> The Commission should not underestimate the complexity inherent in establishing alternative training systems, including the implications for the training of other medical specialists. None of the submissions contains sufficient information to support the contention that an alternative training system would be financially feasible or that the necessary infrastructure would be available to it. Any movement of surgical training to the universities would also entail funding agreements with the Commonwealth. The College submits that significantly more detail is required before the Commission could make a realistic assessment or the College could provide any meaningful response...[197]

13.25 The College also acknowledged the advantages of close collaboration with universities and noted several instances where it is doing this.

Commission view

13.26 In its draft determination, the Commission emphasised the importance of recognising that high quality alternative systems for training and assessing surgeons could exist.[198]

13.27 It noted, in particular, that Australian universities offered surgical training in the first half of the 20th century (see paragraph 4.2). In addition, universities train specialist dentists (in addition to the Royal Australasian College of Dental Surgeons). For example, the Faculty of Dentistry in the University of Sydney offers programs in the dental specialities of orthodontics, prosthodontics, periodontics, oral and maxillofacial surgery, oral medicine and oral pathology, paediatric dentistry, and community oral health and epidemiology.[199]

13.28 The Commission welcomes the fact that key government and educational institutions are now turning their minds to the possibility of the establishment of new medical specialist training programs that may not involve the existing medical colleges.

13.29 At the least, the recognition that alternative training programs could exist is likely to increase pressure on the existing colleges to improve their performance. However, from a competition perspective, the actual entry of one or more competitors (subject to obtaining AMC accreditation) into medical specialist training markets monopolised by the existing colleges would be likely to generate substantially greater benefits in the form of ongoing pressure to maintain and improve quality on all players in the market, as well as pressure to ensure that student fees are no more than they need to be.

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[196]Ibid, p2.
[197]College submission, 3 June 2003, pp27-28.
[198]Draft determination, 6 February 2003, para 13.21.
[199]Draft determination, 6 February 2003, para 13.23.

13.30 The Commission is therefore particularly encouraged by the Hunter Area Health Service and the University of Newcastle proposal (which may go ahead with or without the College's involvement).

13.31 As well as potentially ending the existing monopoly, this proposal potentially signals a move away from medical specialists exclusively controlling the training of their future competitors towards a more balanced group of interests exercising control. In particular:

- a key acquirer of the services of medical specialists – the public health system through Hunter Area Health Service – would be centrally involved;
- medical specialist training would be brought into the broader educational sphere through the involvement of the University of Newcastle; and
- medical specialists would remain centrally involved through their participation as teachers and through the involvement of their colleges if this proves to be possible.

13.32 The Commission enthusiastically welcomes these new developments. However, it also recognises that they are very much in their early stages and that any new program – such as that the Hunter proposal – would need to prove its viability both from a financial perspective and as regards the quality of training it would provide. The proposal is discussed further at paragraph 14.7.

13.33 Currently, the College is the only established surgical training program in Australia and the AHMC has indicated that it supports the College continuing its surgical training and assessment processes, (although not necessarily its monopoly status). This practical fact underpins the Commission's broad approach to the College's application for authorisation.

The relevant market

13.34 Defining the markets affected by conduct proposed for authorisation assists in assessing public benefit and public detriment from any lessening of competition from that conduct. However, depending on the circumstances, the Commission may not need to comprehensively define the relevant markets as it may be apparent that a net public benefit will or will not arise regardless of this definition.

13.35 Three markets are relevant to the College's application. Broadly, these can be described as:

- the market in which surgeons provide their services;
- the market for training surgeons;
- the market for assessing overseas-trained surgeons.

The market in which surgeons provide their services

13.36 Importantly, it has not been argued by the College or interested parties that the market in which surgeons provide their services is wider than the market for surgery. For example, it has not been argued that surgeons participate in a wider market for health care. Instead, the issue has been whether there exists a broad market for surgery or

whether there exists, for example, separate markets for each surgical sub-specialty.

13.37 The Commission agrees that surgeons operate in a distinct market from other health care providers. This conclusion makes further delineation of the market in which surgeons provide their services unnecessary. This is because the College's training and assessment processes regulate entry to the relevant market(s), however this is further delineated.[200]

13.38 Having said this, the Commission notes that the market for surgeons' services might be defined by what hospitals – and particularly public hospitals – demand when seeking to engage a surgeon as a contractor or employee. This seems typically to be a surgeon from a particular surgical sub-specialty, which would suggest that each sub-specialty constitutes a separate market (that is, for the supply of the surgical services of that sub-specialty).

13.39 On the other hand, patients electing to be treated outside the public health system need to engage a surgeon who can perform the particular procedure they require. If surgical procedures were divided up between the sub-specialties, so that patients only had to approach a surgeon from the sub-specialty which performs the procedure they require, then again the surgical sub-specialties would seem to constitute separate markets.

13.40 However, as the College has pointed out, surgeons from different sub-specialties may perform the same surgical procedures. For example, hand surgery may be performed by plastic and reconstructive surgeons, orthopaedic surgeons and general surgeons.[201] In addition, not all surgeons within a specialty may perform the same range of surgical procedures; that is, some will have further specialised in a particular area within their specialty.[202] On this basis, it is arguable that separate markets exist for particular groups of associated surgical procedures (e.g surgical procedures relating to the hand) or even individual surgical procedures. The Commission does not need to resolve these issues for the purposes of this determination.

Geographic scope of the market for surgeons' services

13.41 Importantly, neither the College nor interested parties have argued that the geographic scope of the market in which surgeons provide their services is wider than a national market. Instead, the issue is whether the market is national, state or regional.

13.42 The Commission agrees that surgeons at most operate in a national market and again, does not consider that further delineation is necessary. This is because the College's training and assessment processes – given it is a national body – regulate entry to the market, however the geographic dimension is further delineated.

13.43 Having said this, the Commission notes that, as regards private practice, the geographic dimension of the market in which particular surgeons provide their services could be, depending on the circumstances:

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[200] In addition, these processes only regulate entry to the market and not how surgeons compete once in the market.

[201] College submission, 14 May 2001, p12

[202] Ibid, p12

- local or regional – for example, a city might constitute one local market. Regional markets might exist in and around towns of sufficient size to sustain a surgeon's practice, particularly one from a larger specialty (for example, general surgery); or
- state and territory – for example, state and territory markets might exist for surgeons, particularly from the smaller sub-specialties, who are based in the state and territory capitals. In addition, state and territory legislation regulates entry to the medical profession; or
- national – for example, national markets might exist for highly specialised and complex procedures which are only performed by a small number of surgeons.

13.44 As regards public practice – that is, where surgeons are employed or engaged by public hospitals – there may well be a national market for surgeons. The Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submitted that:

> [t]here is good evidence that medical specialists in Australia operate in a national market for medical specialist services. The effect of this is that a failure of supply in one part of the country, particularly where there is a high demand for the particular specialist services, is likely to affect the supply of specialists in other parts of the country.[203]

Conclusion

13.45 For the reasons given above, it is not necessary to precisely delineate the market in which surgeons provide their services. Having said this, this market or markets, however delineated, are highly relevant to the College's application as they are the markets in which the public benefit and any anti-competitive detriment generated by the College's training and assessment processes are actually realised. Consequently, the evaluation below focuses on the benefit and detriment to hospitals (particularly public hospitals) and patients, who are the consumers in the market(s) in which surgeons provide their services.

The market for training surgeons

13.46 The market for training surgeons is an important market as regards the College's application, as it is the market in which the public benefit and detriment from the College's training and assessment processes is actually generated.

13.47 In particular, as is discussed in detail below, the College's monopoly in this market raises competition concerns as, among other things, it creates a conflict of interest by providing surgeons participating in the College's training and assessment processes with some control (but not total control) over the number of their competitors in the market for surgeons' services in the future. It is also in this market that the high surgical training standards that the College and interested parties agree exist in Australia are generated.

13.48 This market would appear likely be aligned to the market(s) for surgeons' services. For example, if there exists a market for vascular surgeons, then it seems likely that there would also exist a market for training vascular surgeons. However, ultimately, it is not necessary to reach a conclusion on this issue as, however this market is defined, the College still has a monopoly over training and assessment in that market.

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[203]Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p3.

13.49 The geographic scope of the market for training surgeons would appear to be national, given that the College is a national (indeed, Australasian) body. However, even if there exist several smaller geographic markets for assessment, the College would still have a monopoly in each of them. Consequently, it is again not necessary to reach a definitive conclusion on this issue.

The market for assessing overseas-trained surgeons

13.50 Commonwealth, state and territory governments have determined that state and territory medical registration boards should only consider registering overseas-trained surgeons after receiving an assessment from the College as to whether they are equivalent to Australian-trained surgeons. In doing this, governments have created a market for supplying these assessments. Further, they have granted the College a monopoly over this market.

13.51 The market appears to be a national one, given the College is a national body. However, again, even if several smaller geographic markets exist, the College would still have a monopoly in each of them. Consequently, it is not necessary to reach a definitive conclusion on this issue.

Anti-competitive detriment

13.52 Any public detriment generated by the College's training and assessment processes flows from the College's potential to restrict entry into the market in which surgeons participate (however defined).

13.53 Prior to the draft determination, the College submitted that its training and assessment processes:

> raise no competition concerns. Rather they are based on the need to ensure that appropriate standards are maintained.[204]

13.54 In its response to the draft determination, the College submitted that it:

> remains concerned, and has expressed these concerns to the Commission on a regular basis, that there have been no proven allegations that anything the College has done is in breach of the *Trade Practices Act 1974* (the *Act*). The College maintains this position and rejects any statement or conclusion that any of its conduct is anti-competitive or in breach of the Act. The College sought authorisation of its training and assessment processes to remove doubts that were expressed by the Commission and to ensure that the College would not have to engage in unnecessarily protracted and detailed discussions and negotiations with the Commission which the Commission suggested might have led to litigation. Accordingly, the College submits that the Final Determination be amended to ensure that all assertions in the Draft Determination that the College's conduct is anti-competitive or in breach of the Act be removed.[205]

13.55 The College further submitted that the Commission

> has made unsupported or unsubstantiated statements which tend to give the impression that the College has been in breach of the Act.[206]

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[204]College submission 14 May 2001, p8.
[205]College submission, 13 March 2003, p3.
[206]Ibid, p6.

13.56 The College also highlighted a number of judicial statements relating to the proof required to demonstrate a breach of the Trade Practices Act (or any legislative prohibition).[207]

13.57 It is the right of any organisation to argue that its conduct does not breach the Act, as the College does. However, when assessing an application for authorisation, the Commission does not determine whether the conduct it is assessing breaches the Act. This is the function of a court. The Commission's only role is to assess whether an application satisfies the public benefit test (as set out in Chapter 9). In doing this, it assesses both the public benefit and the public detriment generated by the conduct in question. In cases where the Commission is satisfied that public detriment is generated, this may or may not mean that the conduct in question breaches the Act – the Commission forms no view on the issue.

13.58 Similarly, it is also the right of any organisation to argue that Commission findings of public detriment are wrong, as the College does. However, the Commission is concerned that the tenor of the College's submissions displays a broader inability to accept that College processes might impact on competition in the surgical profession in any way whatsoever – even if there might be offsetting public benefits. The College seems effectively to be denying the legitimacy of applying competition principles to its processes.

13.59 For example, the College submitted that the Commission:

> states baldly that the College has significant influence over the number of surgeons entering surgical practice, without any substantiation.[208]

13.60 It seems reasonable to interpret this statement as disputing that the College influences the number of surgeons entering the profession. Yet, it is self-evident that the College's role in setting surgical training standards significantly restricts the number of surgeons entering the profession – this is what entry standards do. The benefit to the public will outweigh the detriment if standards are set at an appropriate level – if not, the public will be disadvantaged by an unjustified reduction in the affordability and availability of surgery.

13.61 While acknowledging that the College has worked co-operatively with health departments and the Commission to refine the conditions proposed in the draft determination, given the College's submissions, the Commission is concerned about the longer-term commitment of the College to ensuring that its processes do not inappropriately impact on competition. It is particularly concerned that there may exist within the College a deep-seated culture of antipathy towards the Act and the benefits it is intended to provide the community.

Anti-competitive detriment from limiting surgeons' numbers generally

13.62 A fundamental feature of Australia's health care system is the rigorous control exerted over the supply of medical practitioners, particularly by governments. As indicated in Chapter 2, the Commonwealth government, among other things, limits the number of places in university medical schools and has limited the ability of doctors to migrate to Australia (unless they wish to work in an area of need).

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[207] Ibid, p6
[208] Ibid, p5.

13.63 As discussed in Chapter 7, Commonwealth, state and territory governments have opted to control the growth in the number of medical specialists, including surgeons, entering practice in Australia through the AMWAC process. Broadly, the AMWAC process seeks to determine the appropriate number of trainees in each medical specialty so as to ensure that a sufficient number of specialists, including surgeons, is available to meet future community needs.

13.64 The Commission understands that governments consider that the public benefits generated by the AMWAC process include:

- a reduced likelihood that surgeons would exploit the significantly greater medical knowledge they possess relative to patients so as to generate unnecessary operations or consultations – that is, a reduced incidence of 'supplier-induced demand'; and

- a reduced likelihood that expensive surgical training will be wasted where surgeons become unemployed or underemployed and their skills deteriorate through lack of use.

13.65 The first consideration goes to a key issue – that of the desire of governments to control expenditure in the health sector. In particular:

- the Commonwealth government is keen to avoid unnecessary increases in Medicare expenditure (the budget for which is uncapped) although other mechanisms also exist to address this issue (for example, the ten year moratorium on allocating Medicare provider numbers to overseas-trained surgeons, unless they work in areas of need); and

- the states and territories are keen to avoid expending scarce public health care funding on unnecessary medical procedures and consultations.

13.66 The Commonwealth Department of Health and Ageing submitted that:

> a medical workforce in excess of population need does not necessarily reduce costs, does not necessarily improve access for under-serviced communities and is unlikely to improve health outcomes. Doctors are extremely expensive to train, and generate high incomes once in the workforce, both through Medicare and patient co-payments. It is the community (through taxation) which funds the major proportion of medical training, as doctors meet only a small amount of their training costs. A balanced medical workforce should therefore be the objective of governments, consumers and the profession.[209]

13.67 Queensland Health noted that:

> it is true that increasing numbers of medical practitioners will create pressure on health costs. A balance needs to be struck between price and access for the individual and the opportunity cost to society as a whole from increasing health spending. Determining this balance is a role for government, not the College.[210]

13.68 As alluded to by Queensland Health, limiting the number of surgeons entering the market in which surgeons participate would reduce competition by limiting the number of competitors in this market. This is likely to have far reaching effects on

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[209]Commonwealth Department of Health and Ageing submission, June 2001, p26.
[210]Queensland Health submission, 4 May 2001, p4.

the market for surgeons' services. In particular, it is likely to generate the following anti-competitive detriment:

- hospitals, and particularly public hospitals, having to pay higher levels of remuneration to surgeons than they otherwise would. This would be likely to:
  - reduce the amount of surgery these hospitals can provide; or
  - force governments to increase public hospital funding at the expense of other potentially beneficial government programs.

  The Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submitted that:

  > it seems evident that medical specialist shortages [are] contributing to the longer term ramping up of the unit costs of medical services in the public hospital system.[211]

  NSW Health submitted that:

  > Workforce shortages are costly for health services to manage and may result in reduced levels of service to the local community where no alternative service is readily available.[212]

- private patients having to pay higher fees for surgery. The Australian Health Insurance Association submitted that:

  > where numbers of a certain discipline are few, their average fees are higher... for example, in South Australia, surgical fees are generally lower than in Victoria. Where they are higher, ie in neurosurgery and hand surgery, there are significantly fewer providers relative to other surgical disciplines than in Victoria, even allowing for differences in population'.[213]

  Higher fees would be likely to result in:

  - increased private health insurance premiums;
  - increased payments required of patients over and above Medicare and insurance rebates – that is, increased patients 'gaps' – thereby reducing the amount of surgery patients can afford; and
  - reductions in the amount of surgery that patients without private health insurance can afford;

- possibly longer waiting lists for surgery and for consultations with surgeons.

13.69 Obviously, there are other factors affecting fee and remuneration levels and waiting lists – for example, the level of public hospital funding, professional indemnity insurance premiums, what patients are willing to pay, and so on. While these factors are often well-known and sometimes controversial, other factors such as restrictions on the number of surgeons entering practice are also important.

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[211] Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p1.
[212] NSW Health submission, April 2002, p4.
[213] Australian Health Insurance Association submission, 4 May 2001, paragraphs 25-26.

13.70 Clearly, governments need to find, as put by Queensland Health, the right balance between ensuring that health care is affordable and accessible by individuals, while ensuring that taxpayers' funds are not expended on unnecessary medical care.

13.71 In assessing the College's application, the Commission is not evaluating whether governments have got this balance right. However, it does need to evaluate the College's application against this background of government controls on the supply of medical practitioners – and particularly surgeons.

13.72 Moreover, the Commission considers that if the growth in the surgical workforce is to be controlled, then this is a matter for government and not the College. As discussed in greater detail below, the College's role should be limited to promoting appropriate standards of surgical training.

Potential sources of anti-competitive detriment from the College's training and assessment processes

13.73 The College has sought authorisation for training and assessment processes under which, in particular, it:

- accredits hospitals for basic surgical training and all hospital posts for advanced surgical training for which accreditation is sought and which meet the relevant standards;
- recommends that state and territory medical boards recognise all overseas-trained surgeons who are equivalent to Australian surgeons; and
- fills all training positions available in advanced surgical training subject to sufficient applicants of the appropriate standard applying.

13.74 The immunity from legal action under the Act that flows from the Commission's grant of authorisation (subject to conditions) will only exist where the College acts in accordance with its application, including the three aspects above.

13.75 Given that the College's application includes the three aspects listed above, with one exception discussed immediately below, any potential anti-competitive detriment from its training and assessment activities relates to its standard-setting role.

13.76 The College has sought authorisation for its processes in selecting basic surgical trainees. As part of this, the Commission understands that the College limits the number of trainees it selects to reflect:

- the number of places in the three basic training skills courses,[214] which in turn depends on the number of available trainers; and
- the number of available advanced surgical training posts.

13.77 This limit is important as it sets a maximum limit on the number of surgeons who can enter practice after completing surgical training.[215] Moreover, it is the only instance

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[214]The Basic Surgical Skills course; the Early Management of Severe Trauma course: and the Care of the Critically Ill Surgical Patients course.

[215]At least as regards surgeons trained in Australia.

where the College goes beyond setting and applying standards. Additional issues are therefore raised, which are discussed below at paragraphs 13.198-13.212.

13.78 Generally, any anti-competitive detriment generated by the College's training and assessment processes is likely to originate from two sources.

Source of potential public detriment: conflict of interest

13.79 The first source is the conflict of interest inherent in practising surgeons (or at least those participating in the College's training and assessment processes) setting and applying surgical training standards.

13.80 Generally, setting and applying surgical training standards simultaneously generates public benefit – for example, by reducing adverse outcomes from surgery – and anti-competitive detriment by restricting entry to surgical practice. In particular, the number of surgeons entering practice is limited by:

- the number of hospitals and hospitals posts that meet College-determined standards;
- the number of applicants for surgical training who meet College-determined standards; and
- the number of surgical trainees who complete the College-determined number of years of surgical training to the College-determined standard.

13.81 This is likely to generate public detriment as outlined above at paragraph 13.68. Generally, as setting standards generates public detriment as well as public benefit – as regards surgery, a significant public benefit – there is a need to ensure that standards are set at a level at which the benefit outweighs the detriment. Queensland Health submitted that:

> The benefits to the community accruing from [the College's] processes in terms of quality and standards must be balanced against the benefits relating to price and access.[216]

13.82 While College Fellows would recognise that the public interest requires that standards be set at a level where the benefit generated outweighs the detriment, it is also reasonable to note that surgeons have a private interest in maintaining and increasing their own incomes. A conflict arises because this private interest might be served by surgeons setting standards at a higher level than necessary to serve the public interest – that is, at a level where the public detriment from excluding potential surgeons from the market outweighs the public benefit.

Source of potential public detriment: College expertise limited to surgical practice

13.83 Standards set by the College impact on the availability, distribution and affordability of surgeons' services. However, the College's expertise is in surgical practice and techniques. It is therefore not well-placed to take into account the aforementioned considerations. This raises the prospect that College Fellows, in administering the College's training and assessment processes, could end up raising surgical training standards beyond the point where the public benefit generated (in protecting patients)

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[216]Queensland Health submission, 4 May 2001, p2.

outweighs the public detriment (from the restriction in the number of surgeons). The College's lack of expertise outside surgical training is highlighted by the matter discussed at paragraph 13.92 below regarding the Australian Orthopaedic Association's non-implementation of AMWAC targets.

Potential means for generating anti-competitive detriment

13.84 The College's standard-setting functions contain two mechanisms which could be used to generate anti-competitive detriment. These are:

- the fact that College Fellows exercise discretion and judgement when determining the level at which to set standards; and
- the existence of subjectivity in College-determined standards.

Discretion involved in setting standards

13.85 The establishment of the College's training and assessment processes involves significant elements of discretion by the College; for example, in determining:

- how rigorous to make the standards for accrediting hospitals and hospital posts;
- how long to make training courses; and
- how hard to set exams or how well trainees must perform during practical training to be assessed as satisfactorily completing it.

13.86 While discretion can be used to ensure that standards are set at a level that ensures that graduates of surgical training are competent and safe, it could also potentially be used to, for example:

- limit the number of new surgeons entering the market by:
  - requiring hospitals and hospital posts to meet inappropriate standards to be accredited for surgical training;
  - setting the standard that applicants for surgical training must meet to obtain a training position at levels that would exclude competent trainees; and
  - setting the standard that surgical trainees must meet to successfully complete training at levels beyond those necessary to ensure that trainees would make safe and competent surgeons (e.g by making examinations overly difficult); and
- delaying the entry of surgical trainees into the market by extending training courses beyond periods required to ensure that graduating surgeons were safe and competent.

Subjectivity in College standards

13.87 The College's standards contain subjective elements. For example:

- certain sub-speciality boards of the College require the hospital to have an

'adequate number of beds and necessary variety of clinical material' and 'adequate personal operative experience for the trainee'. However, what constitutes an adequate number of beds or adequate personal operative experience is not defined;

- the criterion for approving overseas-trained surgeons (albeit a criterion established by government – see paragraph 6.109) is that they are equivalent to Australian-trained surgeons; and

- the criteria for selecting trainees include the ability to interact effectively and affably with peers, mentors, members of the health care team, patients and their families; a capacity for caring, concern and sensitivity to the needs of others; and the ability to contribute effectively as a member of a health team.

13.88 Again, subjectivity can generate public benefits. For example, it seems unlikely that medical graduates with the greatest aptitude for becoming surgeons could be selected using a multiple-choice exam. Strictly objective criteria for the accreditation of hospitals and hospital posts may be too inflexible to take account of differences between hospitals and therefore possibly reduce the number of accredited hospital posts. Similarly, strictly objective criteria for assessing the equivalence of overseas-trained surgeons would be unlikely to be able to take account of the very different backgrounds of candidates.

13.89 On the other hand, subjective criteria could be used to mask, for example, inappropriately limiting the number of hospital training posts or excluding competent overseas-trained surgeons.

Instances generating concerns about College's training and assessment processes

13.90 Generally, the Commission considers that identifying an incentive to participate in conduct generating anti-competitive detriment, along with the means to generate this detriment would, by itself, be sufficient to justify the imposition of conditions on the authorisation being granted to the College. Such conditions would be justified as precautionary measures that ensure that the public benefit outweighs the public detriment over the period of the authorisation.

13.91 However, the Commission has been made aware of concerns raised about the College, some of which add weight to the need to impose conditions. These concerns are assessed below.

Non-implementation of AMWAC targets

13.92 In January 1996, AMWAC completed a review of the orthopaedic surgery workforce. It recommended an initial increased in orthopaedic surgery positions of twelve, with an overall increase of 46 positions by 2006.[218]

13.93 AMWAC issued an updated orthopaedic surgery report in 1998. In that report it noted that:

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[218] *The Orthopaedic Workforce in Australia – supply requirements and projects 1995-2006,* Australian Medical Workforce Advisory Committee, January 1996.

> the Australian Orthopaedic Association initially responded positively to the original [1996] report, however it has not followed through on the recommendations, only increasing total trainees by eight. In addition, there has not been the recommended initial increase in training positions of twelve. Indeed, where the modelling in the initial report suggested training output should ideally be 38, 39 and 40 in 1999, 2000 and 2001 respectively, it will in fact only be 30, 26 and 32.
>
> In not acting in accordance with the recommendations, the AOA raised concerns about the scope of the data used to estimate service trends and the requirement growth targets used in the projection modelling; suggesting that the utilisation trends shown in New South Wales and South Australia may not have been representative of growth nationally or in other States; and that requirements growth may not occur at the estimated 3 per cent per annum. The AOA also comments that as sources of new surgeons include immigration as well as the training program, it needs to be noted that there has been an increase of at least seven overseas orthopaedic surgeons since the completion of the initial review. In the view of the AOA, this has taken the pressure off the need to increased training positions in line with the AMWAC recommendations.[219]

13.94 The Commission views this episode with considerable concern. Effectively, the Australian Orthopaedic Association, which administers orthopaedic surgical training on behalf of the College, ignored an AMWAC recommendation endorsed by Commonwealth, state and territory health ministers in circumstances where both it and AMWAC appear to have believed that the AOA was the body primarily charged with responding to the recommendation. It is no defence for the AOA to argue that the AMWAC recommendation was wrong. The recommendation was endorsed by the AHMC and therefore represented a final decision. Significantly, the Commission notes that the AOA considered that AMWAC had *over-estimated* the target. The significance of this matter is heightened by the evidence now emerging – including in the Birrell report commissioned by the College itself (see paragraph 14.6) – that there is a shortage of surgeons.

13.95 The Commission has commented elsewhere (see paragraph 14.42) on the apparent lack of a systematic process within state and territory health departments to implement AMWAC targets. However, even if this gap was rectified, the College's training and assessment processes still contain means by which it could stymie the achievement of AMWAC targets, as the AOA did. If this occurred, substantial public detriment would be generated.

Assessment of overseas-trained surgeons

13.96 The College assesses overseas-trained surgeons under a scheme established by Commonwealth, state and territory governments. The Commission understands that College Fellows provide this service on a pro-bono basis, although the College charges significant fees for this service (see paragraphs 6.141-6.142).

13.97 Under the scheme, the College formally only makes a recommendation to state and territory medical boards about whether a particular surgeon is equivalent to an Australian-trained surgeon or not. The College therefore submitted that its role could not generate anti-competitive detriment.

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[219] *The Orthopaedic Surgery Workforce in Australia – An Update: 1998 to 2009*, Australian Medical Workforce Advisory Committee, March 1999, p2.

[222] Commonwealth Department of Health and Ageing submission, June 2001, p23.

13.98 However, several interested parties emphasised that this recommendation was almost invariably accepted. For example, the Commonwealth Department of Health and Ageing submitted that:

> the College's assessments do carry great weight in decisions made by other agencies to recognise the qualifications of specialists.[222]

13.99 The NSW Department of Health submitted that, while it did not:

> question that the [College's] role is recommendatory, [it] suggests that the College underestimates the influence of the recommendation. In the Department's experiences, the College's assessment is the *key determinant* [emphasis added] of whether an overseas-trained practitioner is recognised to practise surgery in Australia.[223]

13.100 Moreover, the Medical Board of Queensland submitted that:

> [it] does not possess the expertise or the resources to evaluate the training of overseas specialists... the loss of the capacity to assess the training of overseas specialists [if the College ceased its role] would have devastating consequences on the Board's ability to assure that safe and competent specialist practice is available in the State of Queensland.[224]

13.101 The College has not identified any examples where its recommendation was not accepted in Australia, although it did refer to two cases in New Zealand.[225]

13.102 It appears that, almost without exception, the College's recommendation determines whether an overseas-trained surgeon is granted registration by a medical board. The Commission is therefore satisfied that, for all intents and purposes, the College's recommendation is a decision.

13.103 In any case, if the College's argument that it makes a recommendation were to be accepted, and the public detriment from this role thereby substantially reduced, it would follow that the public benefit from this role would also be substantially reduced, leaving the net public benefit unchanged. For example, if the College's recommendations were routinely ignored, little public benefit and little anti-competitive detriment would arise from the College's role in assessing overseas-trained surgeons.

13.104 Given that the College does, in practice, make a decision, public detriment could arise if the College unreasonably raised the standard at which it considered overseas-trained surgeons would be equivalent to Australian-trained surgeons.

13.105 A number of interested parties raised concerns about the College's process for assessing overseas-trained surgeons.

13.106 NSW Health submitted that:

> the arrangements by which the College assesses the qualifications and skills of surgeons who trained overseas drew significant criticism from some [area health services] while others praised the College's willingness to help find suitable applicants for Area of Need positions.

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[223]NSW Health submission, April 2002, p10.
[224]Medical Board of Queensland submission, 2 May 2001, p2.
[225]College submission, 14 May 2001, paragraph 3.5.8.

> There was a perceived conflict between the College's role as an advocate for its members and its role in impartially assessing new applicants who trained overseas and want to practise surgery in Australia...
>
> The implementation of the College's policy and procedure drew comment from the [area health services] and led to claims of invisible barriers for overseas-trained specialists. The College's submission provides details of a fair and thorough assessment process for overseas-trained specialists. However, the experiences of some [area health services] are that the process is either not followed or inconsistently applied with examples of information booklets not being sent, interviews not being held, or multiple interviews occurring imposing considerable financial costs for applicants, particularly if applying from overseas.[226]

13.107 The Hunter Area Health Service submitted that:

> Feedback we have received from overseas trained doctors reveals the College's current processes often make it unattractive to pursue accreditation in Australia and this substantially reduces the number of such doctors choosing to do so.[227]

13.108 It further submitted that:

> It does not seem logical to say it is acceptable for Australian fellows to seek post graduate training with doctors trained in these overseas programs, but not accept graduates from the same programs as having at least equivalent qualifications to Australian fellows. Indeed, it is paradoxical that surgeons who have trained Australian fellows in nations such as the UK and USA would be required to sit for exams if they wish to practice in Australia.[228]

13.109 Hunter Health submitted that this is particularly problematic for area health services operating in rural and regional areas given the reluctance of Australian doctors to move out of central parts of capital cities.[229]

13.110 The Minister for Health in Queensland, the Hon Wendy Edmond MP, submitted that:

> a common perception exists that specialist colleges have a closed shop approach to overseas-trained specialists. In practice, colleges have assisted a significant number of overseas-trained specialists to work in areas-of-need and to subsequently obtain the Fellowship of the College... Nevertheless, criticism persists in relation to the Colleges' processes for the recognition of overseas-trained specialists...[230]

13.111 In particular, Ms Edmond noted concerns about the:

> inconsistency in standard between colleges for assessment of overseas-trained specialists. There is an impression that some colleges assess against the standard of the average Australian trained specialist while others assess against the standard of a leading specialist. Some are required to sit a part two examination while others less senior are granted fellowship after 12 months of supervised specialist practice in an area of need.[231]

13.112 The South Australian Minister for Health, the Hon Lea Stevens MP, submitted that:

> The Department of Human Services continues to experience a number of difficulties in relation to surgical training and surgical services. In particular, area of need is a significant issue in remote and rural communities in South Australia; there are significant difficulties in obtaining recognition of

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[226]NSW Health submission, April 2002, p10.
[227]Hunter Health submission, 30 May 2003, p9
[228]Ibid.
[229]Ibid.
[230]Submission from Queensland Minister for Health, the Hon Wendy Edmond, 25 September 2002, p1.
[231]Ibid, p2.

overseas-trained doctors, who are surgeons, in terms of assessment and the completion of the requirement for registration to practice as surgeons in the areas of need.

Although in one instance, after a three-year period, the [College's] intervention has been constructive, many of its members have not been helpful in assisting the public health service to maintain and develop surgical services in remote communities in South Australia. I am not confident that the RACS is fully committed to working with my Government to ensure that the provision of surgical services in South Australia is facilitated.[232]

13.113 The Commonwealth Department of Health and Ageing submitted that:

The RACS processes for the assessment of overseas trained doctors are well documented, but that is not to say the processes should not be further improved to make them more timely and transparent.

Current work being undertaken by the AMC and the Committee of Presidents of Medical Colleges (CPMC) to establish a uniform process for assessing overseas trained specialists for area-of-need positions is a positive step to addressing current inadequacies in assessment processes. The Department considers it vital that this work is extended to develop a uniform process for the assessment by Specialist Medical Colleges of all overseas trained specialists.[233]

13.114 In addition, at an Area of Need Forum convened in 2000 by the Committee of Presidents of Medical Colleges and the Australian Medical College, the then Commonwealth Minister for Health and Aged Care, Dr Michael Wooldridge stated that overseas doctors were critical of the lack of transparency and equity in the way that specialist medical colleges assessed overseas-trained doctors, and the unreasonable delay in obtaining decisions. He noted that it was not unusual for doctors to wait between six months and two years to obtain an assessment. He also stated that assessing overseas-trained surgeons might be less problematic if decisions were made on the basis of competency rather than on whether training and qualifications were equivalent. Dr Wooldridge stated that this would constitute a significant and challenging change in focus for the medical colleges.[234]

13.115 The Australian Medical Council made a number of observations in its examination of the College's process for assessing overseas-trained surgeons, including:

- its assessment team was not able to understand why some overseas-trained surgeons might not be excused from a period of on-the-job assessment;[235] and
- while it recognised that not all delays might be the fault of the College, it found it was hard to see the justification for some applications being delayed for substantial periods of time. It noted nine responses which had taken eighteen months or more to complete.[236]

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[232]Submission from South Australian Minister for Health, the Hon Lea Stevens, 11 September 2002, p1.
[233]Commonwealth Department of Health and Ageing submission, June 2001, pp21-22.
[234]Proceedings of Area of Need Forum, 1 December 2000, p3.
[235]The College has since changed it articles to contain the possibility for an applicant to proceed directly to Fellowship without further training, examination or assessment.
[236]*Review of the Education and Training Programs of the Royal Australasian College of Surgeons*, Accreditation Report by the Specialist Education Accreditation Committee of the Australian Medical Council, February 2002, p40.

13.116 Many of the concerns listed above are highlighted in the following example of the College's assessment of an overseas-trained surgeon during the 1990's and through to 2001.

13.117 In 1993, an eminent cardiothoracic surgeon with overseas qualifications sought recognition as a surgeon in Australia after what appeared to be a significant period of successful unsupervised practice in Australia and abroad. He was initially informed by the College that, at the least, he would have to successfully complete advanced surgical training in Australia before he could be recognised. He was later advised that he would also need to pass the Part 1 Basic Training Examination.

13.118 The surgeon appealed the College's decision in 1994. In 1995, being unable to work in Australia, he accepted a surgical position overseas. He did not hear from the College as to the outcome of his appeal until five years later.

13.119 In December 1998, the report of the Committee for the Review of Practice of the Employment of Medical Practitioners in New South Wales, *The Race to Qualify*, was tabled in the New South Wales Legislative Council. The surgeon's situation was highlighted in this report.

13.120 In 1999, the surgeon's case was reported by the media. In particular, a former supervisor – himself an eminent Australian surgeon and a former College Examiner – was reported as saying that requiring him to complete advanced surgical training in Australia was 'like telling Bradman to go to batting school. I would put him in the top five in the world that I have worked with.'[238]

13.121 The College's President in 1999 was reported as defending the College's 1994 decision on the grounds that 'only overseas-trained doctors who have attained a standard that the college sets for its own trainees should be supported for registration. To do otherwise would be inequitable and inappropriate in relation to the standards of surgical care offered to Australians.'[239]

13.122 In December 1999, and after attending another interview, the surgeon was advised by the College that it would recommend that he be registered to practise in Australia. The surgeon formally became a College Fellow in 2001.

13.123 The Commission considers this example illustrates the difficulties that can arise with subjective criteria within the College's processes. In this case, the subjectivity inherent in determining whether an overseas-trained surgeon is equivalent to an Australian-trained surgeon seems to have allowed the College to take different approaches to the same applicant yielding different results. Moreover, it is not entirely clear to the public what these different approaches were and why the College was justified in taking them. Detailed reasons for decisions do not appear to have been provided. Whilst highlighting that the process lacks transparency and accountability to government and the community, the example also demonstrates concerns in respect to the timeliness of decisions.

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[238] *Brilliant surgeon now not good enough for us*, Sydney Morning Herald, 22 January 1999, p1.
[239] *Surgeons to answer for closed shop*, Sydney Morning Herald, 23 January 1999, p3.

The distribution of surgical training posts – criteria for accrediting hospital posts

13.124 There is an obvious need to ensure that sufficient medical practitioners exist to meet patient demands. This need is of immediate significance in rural and regional areas, where there are existing and often severe shortages. Concerns also exist that shortages exist in outer-metropolitan areas where demand for medical services is growing as the population increases.

13.125 For example, Hunter Health submitted that the distribution of surgeons is weighted in favour of large centres, with an unacceptably low ratio of surgeons to population in rural and remote areas resulting in a critical shortage of doctors, both surgeons and GPs, needed to provide adequate and safe levels of health care in outer metropolitan, regional and rural parts of Australia.[240] It further submitted that it is in the public interest to ensure that workforce distribution is equitable between urban and non-urban regions[241] and that:

> the College has an obligation to facilitate a fair and equitable distribution of the surgical workforce between urban and outer metropolitan, regional and rural Australia, and that its training and accreditation systems and processes must be linked to this outcome.[242]

13.126 Governments have been examining ways to address medical practitioner shortages, including by recruiting overseas-trained doctors to districts with workforce shortages – that is, areas of need.

13.127 In its response to the draft determination, the AHMC submitted that:

> The limited interest by Australian graduates in working outside major metropolitan areas has meant an increasing reliance on overseas-trained doctors.[243]

13.128 Prior to the draft determination, the Western Australian Minister for Health, the Hon Bob Kucera APM MLA, noted that:

> Western Australia is experiencing increasing reliance on overseas-trained doctors to staff the WA public hospital system.[244]

13.129 In addition, Commonwealth restrictions on granting visas to overseas medical practitioners provide exemptions for those willing to work in areas of workforce shortage (see paragraph 2.34). The Commonwealth also provides exemptions from the restriction on access to Medicare for overseas-trained practitioners willing to work in areas of need (see paragraph 2.52).

13.130 The location of medical specialist training posts is also relevant to the ability of the public health system to provide medical services in areas with doctor shortages.

13.131 First, surgical trainees are hospital employees providing medical services to patients. The Commission understands that the fact that a hospital post is accredited will typically make it easier for hospitals to fill that post.

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[240]Hunter Health submission, 30 May 2003, p2
[241]Ibid, p5
[242]Ibid, p11
[243]AHMC submission, 25 June 2003, p2.
[244]Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p1.

13.132 NSW Health submitted that:

> there is scope for greater collaboration between the Department, Area Health Services (Hospitals) and the College in the creation of as many accredited training posts as possible to meet the current shortages as well as future workforce requirements.[245]

13.133 Secondly, the Commission understands that training doctors in, for example, rural and regional areas, assists in increasing the number of doctors who ultimately choose to practise in these areas, including in the public hospital system. The Minister for Health in Western Australia, the Hon Bob Kucera APM MLA, submitted that:

> there is good reason to believe that the location of medical specialist training is an important factor in influencing the long term geographic distribution of medical specialist services. For example, it has been acknowledged that training location is an important factor in assisting the long term supply of medical specialists willing to work in rural areas. As a result a trend has commenced to give increased emphasis to establishing medical specialist training posts in rural regional hospitals. A similar argument and strategy could be mounted in respect to achieving the necessary supply of medical specialists in the fast growing outer suburbs of many of the state capital cities. It is important then that there are not artificial barriers limiting the geographical spread of surgeon training posts.[246]

13.134 Hunter Area Health Service and the University of Newcastle submitted that:

> One of the aims of devolution [of general practitioner training from the RACGP] to local partners is to start to correct the inappropriate workforce distribution by providing training based exclusively in areas of need such as outer urban and rural areas.[247]

13.135 On the other hand, the quality of care provided by the public hospital system depends ultimately on the quality of the health professionals working in it. A theme that emerged during the public consultation process was the tension inherent in the current system under which surgical trainees are both hospital employees providing medical services to patients as well as trainees undertaking a surgical apprenticeship which aims to train them to the highest standard possible. For example, in assisting in or performing an operation, a surgical trainee is both providing a service to his or her employer (the hospital), the patient and the community, and engaging in training.

13.136 Tension could arise in a number of ways; for example, where patient care demands require surgical trainees to undertake certain work whereas their surgical training would benefit from them undertaking other work and where surgical trainees' commitments as regards patient care reduce the time they have available for study.

13.137 Tension can also arise in relation to where surgical training takes place. This raises the issue of the College's standards for accrediting hospital posts.

13.138 NSW Health submitted that:

> a teaching hospital in Sydney's west sought to have its four orthopaedic registrar posts accredited. The College advised that a basic criterion for accreditation is a set number of inpatient beds (30 in this instance) per registrar post. The AHS questioned the basis of this accreditation standard and argued that changes in hospital practice such as the increasing day of surgery admissions, reduced length of hospital stay and increasing ambulatory care has resulted in more clinical activity per hospital 'bed'.

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[245] NSW Health submission, April 2002, paragraph 5.1.7.
[246] Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p3.
[247] Hunter Area Health Service submission, 30 May 2003, p7.

> The number of hospital beds *per se* is not a measure of clinical activity. In the end, the College accredited three of the four positions...[248]

13.139 The Minister for Health in Queensland, the Hon Wendy Edmond MP, also noted concerns raised in a recent survey of medical superintendents Queensland Health conducted about accreditation requirements unrelated to training, such as the obligatory provision of office space to trainees.[249]

13.140 Queensland Health also submitted that:

> There is a strong argument in favour of ensuring the quality of training in accredited positions. It is also very important that the criteria against which a post is assessed are based on the best educational principles and good evidence for the link between requirements and training outcomes. The external scrutiny by independent outside bodies such as the Australian Medical Council and accountability to Government is essential. As an example, in specialties with small numbers of specialists in one geographical location, College requirements for supervisor numbers must be reasonable and clearly linked to demonstrated outcomes.[250]

13.141 Hunter Health submitted more generally that College committees exhibited a 'capital city mindset' as:

> they were dominated by urban-based practitioners who do not necessarily appreciate the plight of rural/regional Australia. Rural/regional College fellows who have an interest in addressing the doctor shortage are a minority and are unable to make an impression or drive the necessary change in the College's processes.[253]

13.142 Some health departments also question whether surgical training might not be improved by training in rural and outer-metropolitan settings. NSW Health commended the College's commitment to rural surgical training and particularly its rotational training system under which surgical trainees may work in rural, regional and outer-metropolitan district hospitals.[256] However, it was also concerned that the College's standards for accrediting advanced hospital posts:

> may be inappropriately applied to rural and outer metropolitan hospitals if these hospitals are required to meet the same infrastructure standards as large teaching hospitals. For example, the College's accreditation standards may disadvantage hospitals which provide excellent surgical training opportunities but do not have access to the same resident medical officer staffing levels that large inner city teaching hospitals have. It is a question of the College achieving a reasonable balance between ensuring minimum training standards for all accredited positions while allowing some flexibility in order to recognise the complementary training benefits offered by different types of hospital.[257]

13.143 The Victorian Minister for Health, the Hon John Thwaites MP, submitted that:

> The State supports the proposal to broaden existing accreditation processes to provide opportunities for input from other key stakeholders (for example, other medical colleges) in order to facilitate development of approaches to training which will provide a broad range of experience for trainees. I am particularly conscious of the requirements of regional and rural areas and the importance of

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[248]NSW Health submission, April 2002, p7.
[249]Submission from Queensland Minister for Health, the Hon Wendy Edmond, 25 September 2002, p2.
[250]Queensland Health submission, 4 May 2001, p3.
[253]Ibid, p3
[256]NSW Health submission, April 2002, p8.
[257]Ibid, pp7-8.

> ensuring there is appropriate consideration of the need for rural training opportunities and models which might better support these.[258]

13.144 Overall, the College's accreditation standards clearly generate significant public benefits. However, on balance, they also appear likely to generate public detriment by negatively impacting on availability of medical services in areas with shortages of surgeons.

13.145 More generally, the Victorian Minister for Health, the Hon John Thwaites MP, submitted that:

> it is desirable to move towards a situation where the state actively determines the distribution of centrally subsidised medical specialist training positions, including surgical training posts, whilst acknowledging hospitals will need to create additional training positions to support service needs where necessary.[262]

13.146 NSW Health submitted that:

> [u]ltimately decisions concerning the number and distribution of surgical training posts within the NSW public health service should be a matter for NSW Health to determine in consultation with the College and the NSW Medical Training and Education Council. This will require greater collaboration between the various stakeholders than occurs at present.[263]

13.147 The South Australian Minister for Health, the Hon Lea Stevens MP, submitted that:

> the accreditation by the RACS of training posts without consultation with the DHS is also not acceptable given the responsibilities for the *distribution* [emphasis added], funding and provision of services that this Government has.[264]

13.148 The Commission agrees that the distribution of accredited surgical training posts should be determined by state and territory governments; for example, if there exist fifteen posts in a state or territory that potentially meet the College's accreditation criteria, and the state or territory government only wishes to fund ten of these posts (ie provide a salary plus on-costs), the state or territory government should be able to determine the posts for which accreditation is actually sought.

13.149 This would seem to require those states and territories which do not already have a systematic process for implementing AMWAC recommendations to establish such a process. However, in addition, it highlights the need to ensure that the College's processes for accrediting advanced surgical training posts cannot be used to hinder a government's preference for the distribution of training posts.

Accredited and non-accredited training posts

13.150 A number of submissions have argued that non-accredited advanced training posts exist alongside accredited advanced training posts where the posts are very similar, if not identical. The concern is that the College may not be accrediting all accreditable posts.

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[258]Submission from Victorian Minister for Health, the Hon John Thwaites, 30 September 2002, p2.
[262]Submission from Victorian Minister for Health, the Hon John Thwaites, 30 September 2002, p2
[263]NSW Health submission, April 2002, p10.
[264]Submission from South Australian Health Minister, the Hon Lea Stevens, 11 September 2002, p2.

13.151 NSW Health gave an example where a teaching hospital in western Sydney sought to have its four orthopaedic registrar posts accredited. Ultimately, only three were. It submitted that:

> from the Area Health Service perspective, all four positions were similar from the point of view of workload, training opportunities and supervision.[265]

13.152 NSW Health further submitted that:

> the College needs to clearly justify its decisions in relation to the accreditation of some surgical positions and not others. This is especially important for non-accredited positions where the doctors filling these positions perform similar work, have the same working conditions, have access to the same hospital training facilities (the medical library, formal clinical meetings and surgical education meetings) and receive similar level of supervision as accredited trainees.[266]

13.153 Queensland Health submitted that:

> funded unaccredited and accredited posts exist side by side, often carrying out identical service roles and participating in the same teaching activities.[267]

13.154 The ACT Minister for Health, Mr Stanhope MLA submitted that:

> the reasons for some training posts being accredited whilst others are not are not always clear. Clarity in the reasons for these decisions is needed as there is often little difference between accredited and non-accredited training posts.[268]

13.155 Mayne Nickless submitted that:

> the salary and supervision costs of the unaccredited positions are the same as the accredited positions and there is no real difference in the breadth of experience given to the trainees...[269]

13.156 The Australian Health Insurance Association submitted that:

> where there are two identical posts, often in the same surgical unit in the same recognised hospital, with identical patient mix and numbers, theatre time, supervision and hours, it is unclear why one should be accredited and the other not.[270]

13.157 The Australian Medical Council's review of the College also noted that:

> some, at least, of these [non-accredited] posts appear suitable for training purposes.[271]

13.158 On the other hand, the Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submitted that:

> service posts (ie unaccredited surgical training posts) are not the same as accredited surgical training posts. Many service posts are located in the private sector and have little or no training component. Unaccredited trainees occupying service posts have minimal access to supervised surgery whereas

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[265] NSW Health submission, April 2002, p7.
[266] NSW Health submission, 13 November 2001, p5.
[267] Queensland Health submission, 4 May 2001, p3.
[268] Submission from ACT Minister for Health, Mr Jon Stanhope, 21 October 2002, p1.
[269] Mayne Nickless submission, 22 May 2001, p3.
[270] Australian Health Insurance Association submission, 4 May 2001, paragraph 13.
[271] *Review of the Education and Training Programs of the Royal Australasian College of Surgeons*, Accreditation Report by the Specialist Education Accreditation Committee of the Australian Medical Council, February 2002, p58.

> higher surgical training posts are required to undertake a minimum of 100 operations in each six month period.[272]

13.159 The College emphasised that posts would only be denied accreditation if they did not meet its accreditation standards. It also submitted that it had granted accreditation to almost all posts for which accreditation has been sought. For example, in 2000, the College assessed 63 advanced training posts in 41 hospitals. One post had its accreditation withdrawn and two new posts were not accredited.[273] In 2001, the College assessed 175 advanced surgical training posts. Of these, 172 were approved, two posts were inspected and declined and one post was disaccredited.[274]

13.160 The Minister for Health in Victoria, the Hon John Thwaites MP, noted that:

> The establishment and accreditation of [surgical training] positions is a matter of direct negotiation between the colleges and each hospital and I am therefore not in a position to comment on whether there are specific instances of differential treatment of identical training posts.[275]

13.161 The threshold issue is whether there exist non-accredited posts which are essentially identical to accredited posts. While the Commission has received opposing submissions on this issue, the weight of submissions leads to a conclusion that the identical accredited and non-accredited posts appear likely to exist except, it seems, in Western Australia.

13.162 This conclusion raises the issue of how non-accredited posts exist, particularly given that the College rarely denies accreditation. A large part of the answer appears to be that accreditation has never been sought for these posts.[276] The question is why not.

13.163 It appears that College Fellows have considerable influence over when accreditation is sought for a training post. This influence may arise because the College itself initiates the process for seeking accreditation. Alternatively, where a hospital administration wishes to seek accreditation, it would seem likely that the views of College Fellows in the surgical department in which the post is located would be highly influential on whether the application for accreditation is pursued with the College.

13.164 Possible reasons why accreditation may not have been sought for non-accredited posts include:

- that the target number of training posts agreed by the Australian Health Ministers' Conference (on AMWAC advice) has been met. In this case, hospitals and College Fellows working in them may consider that there is no reason to seek accreditation for particular posts, even if they were likely to meet accreditation standards. The Victorian Department of Health noted the existence of AMWAC targets and submitted that it was:

  > satisfied that the RACS admits sufficient numbers to specialist surgical training to fill the positions so determined.[277]

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[272] Submission from Western Australian Minister for Health, the Hon Bob Kucera APM, 23 September 2002, p2.
[273] College submission, 30 April 2001, p2.
[274] College submission, 14 March 2002, p1.
[275] Submission from Victorian Minister for Health, the Hon John Thwaites, 30 September 2002, p2.
[276] See NSW Health submission, April 2002, p8, footnote 2.

NSW Health noted that:

> with the exception of ENT surgery, NSW is largely on target with respect to the recommended training numbers set by AMWAC through its various reports on the surgical workforce. If all funded surgical positions were filled with accredited trainees, then NSW would exceed the workforce targets set by AMWAC in some specialty areas;[278]

- hospital administrators and/or College Fellows consider that seeking accreditation for a surgical post would be pointless as they consider that the post (or the hospital it is located in) would be unlikely to meet the accreditation criteria; or

- it may not be able to include the holder of the training post in after-hours educational activities.

13.165 As regards the first point, it appears that any informal oversight role played by the College in relation to the implementation of AMWAC targets is limited. Moreover, the Commission is not aware of how the College actually undertakes any such role. As such, the process by which College Fellows would determine that accreditation should not be sought for particular training posts because AMWAC targets had been met is unclear. This creates some uncertainty about the validity of any argument that College Fellows are not seeking accreditation for hospital posts (or are opposing hospital administrators seeking applications for accreditation) because AMWAC targets have not been met.

13.166 Given that the issue being considered is why accreditation has never been sought for apparently identical non-accredited posts, the second dot point above appears to be largely irrelevant.

13.167 On the basis of the information before it, the Commission is sceptical of the third point (relating to after-hours educational activities). In particular, any argument of this nature would be undermined by the substantial lack of transparency about the after-hours educational activities for surgical trainees. In particular:

- it is not clear what these after-hours educational activities are;

- it is therefore not clear whether they are of such educational value as to be a legitimate limit on the number of accredited posts;

- even if they are a legitimate limit in theory, it is not clear how the actual limit on the number of participants in the activities (and therefore accredited posts) has been determined in practice; and

- it is not clear that the activities have been filled to this limit.

13.168 In addition, the College has advised that:

> After hours educational activities for trainees vary in their specifics from hospital to hospital and State to State...[279]

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[277]Victorian Department of Health submission, 21 August 2001, p1.
[278]NSW Health submission, April 2002, p8. See also Table 7.8 at paragraph 7.44 which supports NSW's submission.
[279]College submission, 24 July 2002, p2.

13.169 However, if these activities were of sufficient importance to distinguish accredited from non-accredited posts, it would seem necessary for them to be organised on a consistent national basis with a standard curriculum.

13.170 A fourth possible reason is that College Fellows may have not sought accreditation, or opposed hospital administrators seeking accreditation, for anti competitive reasons. However, the Commission has not received information supporting this possibility.

13.171 Overall, the Commission is unable to reach a conclusion on this issue on the information available to it.

Confidentiality of complaints

13.172 Since receiving the College's application for authorisation, the Commission has received around 20 complaints from Australian surgeons and specialists, overseas-trained surgeons, surgical trainees and candidates for surgical training. Almost all complainants have required that their complaint be kept confidential. The Commission has also received a string of informal complaints from complainants who are unwilling to go public. Overall, an unwillingness to speak out publicly against the College has been a recurring theme, with complainants citing a fear that:

- for surgical trainees, the College learning of their complaint would end their chances of successfully completing surgical training;
- for candidates for surgical training (particularly advanced surgical training), that the College learning of their complaint would end their chances of winning a training place, particularly where they intend to re-apply in the following year in the hope of a better result;
- for overseas-trained surgeons, that the College learning of their complaint would end their chances of obtaining the right to practise surgery in Australia; and
- for surgeons and other specialists, that the College learning of their complaint would detrimentally affect their practice.

13.173 This almost universal requirement for confidentiality suggests that a widespread perception exists within the medical community that the College does not necessarily operate in a fair and appropriate manner.

Lack of transparency

13.174 Interested parties were concerned about a lack of public transparency about the College's training and assessment processes. For example, the Minister for Health in Western Australia, the Hon Bob Kucera MP submitted that:

> the present arrangements do not provide sufficient information for government to determine the extent to which RACS policies and processes... are factors contributing to shortages of surgeons...[281]

13.175 NSW Health submitted that:

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[281] Submission from the Western Australian Health Minister, the Hon Bob Kucera, 9 May 2002, p2.

there is a potential to increase the public benefit of the College's arrangements through more open and transparent processes for selection of advanced trainees, accreditation of hospital posts and the assessment of overseas-trained specialists...[282]

13.176 The Department of Human Services in Victoria submitted that:

the process by which the College accredits surgical trainee posts at specific hospital locations is not necessarily made clear to the Department and the hospitals concerned. It is important that this accreditation process is fully transparent to demonstrate that the College is objective in its workings and that the service requirements of the hospital are not unduly restricted.[283]

13.177 While not of itself showing that the College's training and assessment processes are being improperly administered, a lack of transparency contributes to perceptions that this might be the case.

13.178 Moreover, given the ultimate responsibility of state and territory governments to implement AMWAC targets, including the distribution of training posts (as long as the College's accreditation standards are met) they are entitled to, for example, know the details of the process for accrediting advanced hospital posts and be provided with formal reasons as to why particular posts may not have been accredited.

13.179 The Commission acknowledges that the College's website (www.racs.edu.au) provides a range of information about its training and assessment processes.

Involvement of specialist societies

13.180 A further concern relates to the role of specialist societies in the training programs for neurosurgery,[289] orthopaedic surgery,[290] otolaryngology – head and neck surgery[291] and urology.[292] While the involvement of the relevant specialist societies does not, of itself, necessarily generate public detriment, and while the College has advised that the societies are subject to its direction as regards their role in the training programs, the Commission agrees with the AMC's conclusion that the involvement of the societies:

raises significant questions of responsibility, consistency and accountability.[293]

13.181 NSW Health submitted that:

The assessment of overseas qualifications is further obscured by the complex structure of the College and the relationship between it and its affiliated specialty boards. While the College is regarded as a

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[282]NSW Health submission, 13 November 2001, p2.
[283]Victorian Department of Human Services submission, 21 January 2002, p1.
[289]The Neurological Society of Australasia.
[290]The Australian Orthopaedic Association and the New Zealand Orthopaedic Association.
[291]The Australian Society of Otolaryngology – Head and Neck Surgery and the New Zealand Society of Otolaryngology – Head and Neck Surgery.
[292]The Urological Society of Australasia.
[293]*Review of the Education and Training Programs of the Royal Australasian College of Surgeons*, Accreditation Report by the Specialist Education Accreditation Committee of the Australian Medical Council, February 2002, p13.

single entity, it is comprised of boards, committees and affiliated societies. A clear explanation of governance within the College, particularly the relationship between each sub-specialty and the College and the decision-making powers of each in relation to the assessment of overseas-trained practitioners should be made available on the College's website.[294]

13.182 Generally, the Commission would be concerned about the involvement of independent specialist societies in particular training and assessment programs without any apparent formal relationship between them and the College. This would create considerable uncertainty about the ability of the College to ensure that the training programs are administered in an appropriate manner.

13.183 The draft determination proposed that, to the extent that it had not already done so, the College be required to reach agreements with each relevant specialty society specifying the relationship, responsibilities and accountabilities of that society to the College.

13.184 The Commission acknowledges that the College has signed memoranda of understanding with each relevant specialist society and is currently negotiating service agreements.[295]

Training and examination

13.185 The College's surgical training courses could generate anti-competitive detriment if they were unreasonably long. One way of assessing whether this is the case would be to compare them with course lengths overseas. Table 13.1 indicates the length of training courses in Canada, Australia, the United Kingdom and the United States where comparable sub-specialties exist. The Table gives the total length of the surgical training course; that is, including basic and advanced surgical training.

Table 13.1: Length of surgical training (combines length of basic and advanced surgical training)

Specialty	**Canada**	**Australia**	**United Kingdom**	**United States** (differs between universities)
General Surgery	5 years – University of Western Ontario	7 years	8 years	5 years – Yale University, University of Chicago, Columbia University, Stanford University 6-7 years – UCLA, University of Michigan

[294]NSW Health submission, April 2002, p11.
[295]College submission, 3 June 2003, pp18-19.

Cardiothoracic surgery	-	8 years	8 years	8-9 years – UCLA
Paediatric surgery	-	8 years	8 years	-
Neurosurgery	6 years – University of Toronto and University of Dalhousie	8 years	8 years	5 years – University of Chicago 7-8 years – University of Michigan
Plastic surgery	5 years – University of Toronto and University of Western Ontario	8 years	8 years	-
Orthopaedic surgery	6 years – University of Toronto; 5 years – Western Ontario and Dalhousie	6 years	8 years	6-7 years – University of Michigan
Urology	-	7 years	7 years	-
Otolaryngology	-	7 years	8 years	5-6 years – UCLA 7 years – University of Chicago

13.186 This information suggests that the length of the College's training courses is broadly consistent with those overseas, and that they therefore are unlikely to generate significant public detriment. The Commission notes however that the length of the College's training courses is towards the top end of the range when compared with those overseas. Given this, competition concerns may arise if the lengths of these training courses were to be extended.

13.187 Public detriment could be generated if examinations or assessments of practical training are made unreasonably difficult to pass.

13.188 However, historically, a high percentage of surgical trainees successfully complete the Part 2 Exam – over 90 per cent between 1995 and 1998, although not necessarily at the first attempt. This suggests that the exam is set at an appropriate level of

difficulty.

13.189 Broadly, surgical trainees are eligible to undertake the Part 2 Exam if they have performed satisfactorily during training. A comparison of the number of accredited surgical trainees and the number of trainees undertaking the Part 2 Exam appears to indicate that the vast majority of trainees are judged to have performed satisfactorily during training. This suggests that training is assessed reasonably.

13.190 As regards basic surgical training, concerns about the Part 1 Multiple Choice Exam are discussed below at paragraph 13.194-197.

13.191 The second element of the Part 1 Exam – the Objective Structured Clinical Exam – had an average pass rate of nearly 80 per cent between 1995 and 2000. This suggests that the exam is set at an appropriate level of difficulty.

13.192 Generally, NSW Health submitted that there is no need:

> to make changes to the standards that surgeons have to meet to pass the fellowship examinations.[296]

13.193 Overall, the Commission considers that the College's training programs and examinations generate minimal public detriment.

Basic surgical training Multiple Choice Question (MCQ) Examination

13.194 Basic surgical trainees generally take the College's MCQ Examination in their second year of training. Between 1995 and 2000, the average pass rate for this exam was just over 40 per cent (see Chapter 6, Table 6.3).

13.195 The MCQ Exam was reviewed by Professor Bernard Rechter, formerly of the Australian Council on Education Research and Monash University, who found that, among other things, the examination used penal marking (that is, it penalised wrong answers) which was 'difficult to justify legally'.[297]

13.196 However, even allowing for this marking scheme, the Commission considers that the average pass rate between 1995 and 2000 seems too low, particularly when the high academic calibre of the trainees taking the examination is taken into account. This suggests that the exam was made unnecessarily hard.

13.197 While it does not appear that the College deliberately used this exam to ration the number of basic surgical training graduates, this issue does highlight how the discretion involved in the College's standard setting role might, by setting the standards of exams that surgical trainees must meet at unreasonably high levels, be used to restrict entry into surgical training or practice.

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[296] NSW Health submission, 13 November 2001, p1.

[297] *The Royal Australasian College of Surgeons Multiple Choice Examination*, Professor Bernard Rechter. See College submission, 14 March 2002, Attachment 2, p2.

Limiting the number of basic surgical training posts

13.198 The Commission understands that the College limits the number of accredited basic surgical trainees it selects so as to reflect:

- the number of places in the three basic training skills courses,[300] which in turn depends on the number of available trainers; and
- the number of available advanced surgical training posts.

13.199 Imposing a limit on basic surgical training positions is a significant change to the College's training and assessment processes. Traditionally, basic surgical training has been, in relative terms, easier to enter and advanced surgical training has been difficult to enter. Now the bottleneck that existed at the entrance to advanced surgical training is being brought forward to the entrance to basic surgical training.

13.200 Moreover, the limit on the number of basic surgical training posts is highly important, as it sets a maximum limit on the number of (Australian-trained) surgeons who will be able to enter practice after completing the required number of years of training. Consequently, any unreasonable restriction on the number of basic surgical training posts by the College would generate public detriment.

13.201 Presumably, the actual limit on basic surgical training posts in any given year is the lower of the two 'subsidiary' limits set out in paragraph 13.198. The first subsidiary limit – the number of skills course places – raises issues including:

- whether the three basic training skills courses are essential to basic surgical training; and
- whether the trainer-trainee ratio is justifiable.

13.202 These issues are difficult to assess without access to specialist expertise in surgical training, which is largely held (in Australia, at least) by the College.

13.203 The Commission understands that the second subsidiary limit – the number of advanced training places – is intended to ensure that the time and resources trainees, surgeons and hospitals expend on basic surgical training is not wasted where trainees are unable to win places in advanced surgical training.

13.204 While this argument has merit, a number of concerns also arise. First, the imposition of the limit adds considerable weight to the need to ensure that all possible training posts are accredited (subject to them meeting appropriate standards and to government workforce decisions).

13.205 Second, the imposition of this second subsidiary limit could result in advanced training posts not being filled where, for example:

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[300]The Basic Surgical Skills course; the Early Management of Severe Trauma course; and the Care of the Critically Ill Surgical Patients course.

- new advanced training posts are accredited during the two-year basic training period that the College did not foresee when it determined the limit on the number of basic surgical trainees at the beginning of this period; and/or

- some basic surgical trainees fail to complete basic training within the four year time limit.[301]

13.206 These possibilities highlight that, in setting a limit on basic surgical training, the College is actually forecasting the number of advanced training posts available two years into the future, as well as the number of trainees available to fill these posts. In doing this, the College is exercising judgement and discretion, albeit within limits – that is, the current number of advanced training posts would presumably set a benchmark for forecasting the number of posts likely to be available two years into the future. Concerns about how the potential anti-competitive detriment generated by the exercise of discretion by the College are discussed above.

13.207 Two further concerns arise about imposing a limit on basic surgical training posts. Both relate to the fact that basic and advanced surgical trainees and 'intermediate' trainees in non-accredited training posts are hospital employees.

13.208 First, the College's decision to limit the number of basic surgical training positions limits the number of potential hospital employees possessing the skills and experience gained as basic surgical training progresses.

13.209 The Minister for Health in South Australia, the Hon Lea Stevens MP, submitted that:

> In 2002, the RACS accredited 10 basic surgical training posts in South Australian teaching hospitals, compared with 20 in previous years... the apparent change did impact on the staffing of South Australian public hospitals.[302]

13.210 Second, the College's decision is likely to largely eliminate, within a few years, the existence of basic surgical training graduates working in non-accredited positions while seeking to obtain an advanced training post. As indicated above, while this may have merit by minimising any delay between finishing basic surgical training and commencing advanced training, it will also deprive public hospitals of employees with presumably valuable, if limited, surgical skills. This may impact negatively on the quality of patient care. Having said this, it may be possible for overseas-trained surgeons whom the College considers to have qualifications and experience equivalent to basic surgical training to fill at least some of the gaps.

13.211 Finally, the issue arises as to how basic surgical training posts are distributed within Australia where not all posts in hospitals that meet the required standard are actually filled. The South Australian Minister for Health, the Hon Lea Stevens MP submitted that:

> it is believed that there were thought to be serious inconsistencies in the assessment of candidates between the various states and that these inconsistencies worked against South Australia. It also

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[301] Although in either case, at least some posts may be able to be filled by overseas-trained surgeons required to complete advanced training before being able to practise in Australia.

[302] Submission from the South Australian Health Minister, the Hon Lea Stevens, 11 September 2002, p1.

[304] Submission from South Australian Health Minister, the Hon Lea Stevens, 11 September 2002, p2.

> appears that the number of positions was determined amongst other factors on the training capacity of each state and that the RACS significantly underestimated the training capacity of South Australia.[304]

13.212 The Commission notes that, to the extent that surgeons are likely to enter practice in the region in which they were trained, an inappropriate distribution of training posts could lead to imbalances in the number of surgeons in Australia; that is, an oversupply in some states and an undersupply in others. This would generate public detriment. Concerns of this nature add weight to the need to increase the transparency and public accountability of the College so as to ensure that its training and assessment processes do not generate (unintended) public detriment. The Commission will be re-examining this issue closely when the College's authorisation expires.

National selection process

13.213 The South Australian Minister for Health, the Hon Lea Stevens MP, submitted that:

> The current situation whereby the RACS selects accredited trainees on a *national* [emphasis added] basis without the involvement of the Department of Human Services is not acceptable to this Government.[305]

13.214 The Minister for Health in Queensland, the Hon Wendy Edmond MP, submitted that:

> Queensland Health has concerns about the national selection process... The Brennan principles do not require a national selection process. Queensland maintains that the College's role is to assess the suitability of a candidate for their training program. The responsibility of employment lies with Queensland Health; those who have made an application to the advertised training vacancies should be considered in the first instance.[306]

13.215 Queensland Health submitted that:

> The national selection process for advanced training is used by the RACS to decide allocation of posts, even though some of these trainees allocated to Queensland have not applied for a position in this State.[307]

13.216 In its draft determination the Commission noted that, particularly in light of the above comments, some states and territories may have concerns about the College's move to national accreditation processes. In particular, the Commission noted that concerns may exist that successful applicants from the more populous states may be less willing to take up positions in less populous states and territories, although not vice-versa. The Commission invited interested parties to provide information on this issue.

13.217 Hunter Health submitted that the national selection program (unintentionally) works against outer metropolitan, rural and regional areas.[308]

13.218 The College argued that:

> A state by state selection process may infringe the principles of section 92 of the Constitution by discrimination in favour of candidates resident in a particular state: Cole v Whitfield (1985) *165 CLR 360* and therefore the best candidates would not necessarily be appointed to each position and the Australian community may not receive the highest quality of surgical services....However, this is

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[305] Ibid.
[306] Submission attached to AHMC submission, 25 June 2003.
[307] Queensland Health submission, 4 May 2001, p3.
[308] Submission by Hunter Health, 30 May 2003, p2

> unlikely to be the case where selection is made on the basis of merit, as is the case under the current, national selection process.[309]

13.219 The College further noted that a breach of section 92 of the constitution could leave it open to potential litigation.[310]

13.220 On balance, the AHMC supported the retention of a national selection process but recognised the need to clarify the extent of the problem. It further submitted that:

> some jurisdictions have expressed reservations about the possibility of a national merit selection system resulting in no, or only a few, applicants for training places from their jurisdiction securing places in their "home State", and/or the possibility that the State's investment in a trainee will not be recouped by ultimate practice in the State of training, as a trainee will return to his or her original State either during, or on completion of, training. It is proposed that AMWAC, through its Career Choice and Workforce Participation longitudinal study, in cooperation with the College, monitor the movement of trainees over a reasonable period of time, to establish the extent of the issue.
>
> As stated above, some jurisdictions are concerned to ensure that their investment in surgical trainees is recouped as far as possible, and to secure an adequate surgical workforce for their jurisdiction. In recruiting applicants to training posts, jurisdictions therefore wish to retain the opportunity to consider matters such as State of origin or willingness to sign an undertaking to remain in the post for a specified period. As these matters relate to jurisdictions as employers, they are not necessarily affected by the Commission's draft determination.[311]

13.221 The AHMC noted that it intended to explore with the College the potential for solutions that would increase the likelihood of jurisdictions securing an adequate future surgical workforce and that this issue will be included in the memoranda of understandings being developed between the College and the jurisdictions[312] (see paragraphs 13.394–397).

13.222 On one hand, it appears that the national selection process may unintentionally contribute to imbalances in the supply of surgeons between states and between metropolitan and rural and regional areas and thereby generate a public detriment. On the other hand, the apparent constitutional constraints may give the College little choice but to continue with a national selection process. Given this, the Commission supports the process proposed by the AHMC to deal with any public detriment arising from the national selection process.

Public benefit

High standards of surgery

13.223 The key public benefit claimed by the College is that its processes underpin high standards of surgery in Australia. Interested parties almost universally accept this claim.

13.224 The Commonwealth Department of Health and Ageing submitted that:

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[309]College submission, 13 March 2003, p17.
[310]Ibid, p16.
[311]AHMC submission, 25 June 2003, p13.
[312]Ibid, p14.
[315]Commonwealth Department of Health and Ageing submission, June 2001, p4.

> Australian surgeons trained by the College have an excellent reputation internationally in terms of clinical competence and professionalism.[315]

13.225 NSW Health submitted that:

> Australia is a world leader in the development and maintenance of professional medical standards. This is in large part due to the specialist medical colleges whose training programs are highly valued by their Fellows, their trainees, overseas colleagues, consumers and government. In particular, Australian surgeons have an excellent reputation in terms of clinical expertise and professionalism.[316]

13.226 The Victorian Department of Human Services submitted that:

> there is widespread agreement that the standards of education and professional practice in Australia are high by international standards.[317]

13.227 Queensland Health acknowledged:

> the significant role played by the [College] in ensuring... the internationally-recognised high standard of surgical services in Australia.[318]

13.228 High surgical training standards are likely to generate significant benefits for the community by excluding unqualified surgeons from the market, thereby contributing to:

- a lower rate of adverse outcomes from surgery leading to longer and better lives for patients; and
- reduced time in and/or fewer visits to hospital, thereby reducing costs for the public hospital system, Medicare, private health insurers and ultimately consumers.

13.229 Clearly, a range of other factors will also contribute to achieving these outcomes. This fact is highlighted by the establishment by health ministers in January 2000 of the Australian Council for Safety and Quality in Health Care to lead national efforts to improve patient safety and the quality of health care in Australia.[319]

13.230 In absolute terms, high surgical training standards are clearly a substantial public benefit (although the Commission notes that it has not been provided with empirical evidence supporting the College's claim).

13.231 However, as indicated in Chapter 9, the Commission applies the 'future with-and-without test' to public benefit claims, which involves establishing a 'counterfactual' – that is, an assumption about the state of the market should authorisation be denied. It is the public benefit generated by the College's training and assessment activities relative to the public benefit that might exist if authorisation were to be denied that is important.

13.232 In this case, it seems likely that, if authorisation were denied, the College would cease its training and assessment activities. The Commission has discussed the possible emergence of alternative surgical training programs at paragraphs 13.15-33.

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[316]NSW Health submission, April 2002, p4.
[317]Victorian Department of Human Services submission, 23 August 2001, p1.
[318]Queensland Health submission, 4 May 2001, p1.
[319]See http://www.safetyandquality.org.

However, given that thinking on alternative programs is in its early stages, if the College ceased its training and assessment processes now, the Commission considers it likely that Commonwealth, state and territory governments would need to establish (or co-ordinate the establishment of) a new system for training surgeons and for assessing overseas-trained surgeons.

13.233 It is not necessary to predict precisely how such a system might look for the purposes of assessing the College's application. Health departments or area health services might be established to administer a new system. University medical schools might become involved. The system might be national or it might be regionally-based. There might be several competing training programs.

13.234 However, whatever the overarching structure of a new system, it would seem likely that most of the internal elements of the current system would be retained – for example, surgical trainees would be trained in hospital posts by surgeons; they would probably need to pass an exit exam and so on. Similarly, surgeons would be needed to assess the qualifications of overseas-trained surgeons. It is unlikely that governments would allow a return to the system in place before 1990, where overseas-trained surgeons were required to pass an exam administered by the AMC. This exam focused on general practice, and was therefore inherently difficult for specialists to pass.

13.235 Having said all this, establishing a new system would clearly be difficult. Queensland Health submitted that:

> it is unlikely that the programs conducted by the RACS could be readily reproduced by another body and, should another body assume the RACS role, the commercial cost of providing the programs would be disastrous.[320]

13.236 Initially, Commonwealth, state and territory governments would seem to need to negotiate an agreement on the design and funding of the new system. During this period, formal training is likely to take place under some form of transitional scheme, but the standard of any training undertaken may be uncertain if surgeons are not fully engaged.

13.237 The new system would then need to be implemented. Importantly, the co-operation of surgeons would need to be obtained to ensure the system worked effectively. This might be difficult if surgeons consider that the new system is flawed. On the other hand, the facts that surgeons' claims to possess a strong professional ethos and that the status of the surgical profession would be likely to fall if surgical standards fell suggest that surgeons would ultimately commit to a new system.

13.238 The overall length of the period before surgical training standards returned to their current level is difficult to predict. However, governments would likely be under considerable pressure to minimise its length.

13.239 Given the above, it is difficult to draw firm conclusions about the magnitude of the public benefit generated by the high surgical training standards prevailing under the College's training and assessment processes. What can be said though is that the public benefit would only last as long as it takes for a new system to reach the same

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[320]Queensland Health submission, 4 May 2001, p1.
[322]College submission, 14 May 2001, p45.

standards as the College's system. While this public benefit is likely to be significant, the Commission considers the College's claims as to its magnitude are overstated.

Pro-bono training

13.240 The second major public benefit claimed by the College is that surgeons organise and provide training on a pro-bono basis. In particular, they claim that surgeons provide pro-bono work valued at more than $230 million per annum (not including $70 million in capital costs).[322]

13.241 Two issues arise:

- to what extent do surgeons currently provide training and associated services on a pro-bono basis; and
- to the extent that they do, is a public benefit generated.

13.242 Training provided by surgeons in hospital hours – that is, the surgical apprenticeship – comprises over 90 per cent of the value of surgeons' pro-bono work as claimed by the College.

13.243 Some state and territory governments have submitted that surgeons are paid for this training. The South Australian Minister for Health, the Hon Lea Stevens MP, advised that:

> the Visiting Medical Officers' Award and the full time and part time South Australian Salaried Medical Officers' Award, through which clinicians (including surgeons) are employed in South Australian Metropolitan Public Hospitals, have a requirement for teaching and training of both undergraduate and post-graduate medical students.
>
> The rate of remuneration includes a component of teaching of postgraduate students and the allocation of duties by hospitals includes this requirement.[323]

13.244 The Queensland Department of Health submitted that:

> Training occurs as an integral part of service provisions and in this situation is paid... Contracts of employment for VMOs, as outlined in position descriptions, usually require them to provide training. No specific payments are made for training which is regarded as an integral part of professional duties.[324]

13.245 The Tasmanian Department of Health and Human Services, while conceding that the issue was difficult, stated that:

> Some of the training provided by surgeons is undertaken in paid time, in the case of both full time and sessionally paid surgeons. For instance, in the conduct of surgical procedures in the operating theatre, during ward rounds and outpatient clinical attendances, the surgeon would be providing training to junior medical staff in the course of patient treatment. Other training activities such as lectures and workshops would sometimes be conducted in paid time, although more frequently those activities would be undertaken in unpaid time.

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[323]Submission from South Australian Health Minister, the Hon Lea Stevens, 11 September 2002, p2.
[324]Queensland Health submission, 27 September 2001, p3.

> VMO contracts for surgeons contain a clause that the surgeon 'may be required to provide teaching and/or research' as a component of the contract. Surgeons are paid for teaching activities provided in accordance with such a requirement in their VMO contract.[325]

13.246 The University of Queensland submitted that:

> it must be understood that although surgeons train their junior colleagues, for a very significant amount of the time whilst they are doing this they are receiving remuneration for the surgery that they are performing either through sessional payments from the public health system, as full time employees within the State health or university system or through operating fees charged to private patients.[326]

13.247 On the other hand, the College maintains that only those surgeons approved by it may provide training – implying that surgeons elect whether or not to participate in training by applying to the College for approval. Further, it claims that those that elect to participate do not receive additional payments from hospitals.

13.248 The Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submitted that:

> employment contracts for VMOs do not stipulate surgeons are required to provide surgical training.[327]

13.249 In addition:

> surgeons providing surgical training have less time available to attend their consulting rooms and work in the operating theatre. As a result their capacity to earn income is reduced... the potential to lose income is reduced if they are contracted on a sessional payment basis [as VMOs are]...[328]

13.250 The Australian Healthcare Association, which is the national industry association for the public hospital and healthcare sector, submitted that it:

> supports the view that [College Fellows] do provide a valuable pro bono service to the health care system. In doing so, they no doubt derive benefits in terms of skill maintenance, enhanced professional standing, and perhaps a competitive advantage. This is an acceptable quid pro quo.[329]

13.251 Finally, the AMC, in its review of the College, considered that College Fellows provide training 'voluntarily'.[330]

13.252 The ACT and NSW health departments appear to fall somewhere in-between the two views discussed above.

13.253 NSW Health submitted that:

> there is a considerable amount of pro-bono teaching within the hospital system. The contribution of individual specialists to the teaching of trainees is the mainstay of the current service-based specialist medical training system in Australia.
>
> However, it should be noted that contracts for VMOs working at teaching hospitals usually include the provision of teaching and training of post-graduate medical officers as part of the professional services provided by the VMO. This provision is set out in Clause 4(6) of the Public Hospitals (Visiting Medical Officers – Sessional Contracts) Determination 1994. The time billed by VMOs includes time

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[325]Tasmanian Department of Health and Human Services submission, 31 August 2001, pp3-4.
[326]University of Queensland submission, 29 May 2003, p1.
[327]Submission from the Western Australian Health Minister, the Hon Bob Kucera, 23 September 2002, pp4-5.
[328]Ibid.
[329]Australian Healthcare Association submission, 22 March 2002, p4.
[330]Australian Medical Council, Accreditation Report: Review of the Education and training Programs of the Royal Australasian College of Surgeons, February 2002, p40.

> spent teaching registrars which usually occurs in the context of providing clinical care in the operating theatre or on the wards.[331]

13.254 The ACT Department of Health, Housing and Community Care submitted that:

> surgeons provide surgical training on a partial pro-bono basis. VMO contracts explicitly require surgeons to provide training. However, no particular payment is linked to this requirement.
>
> The Department submits that it is implicit in accepting a VMO appointment that surgeons provide surgical training. However, in some specialities it would be difficult to enforce this requirement. In particular, in many cases (e.g vascular surgeons), it would be hard to terminate the contracts of surgeons who refuse to provide training services and recruit replacement surgeons with the existing surgeons still in the market.[332]

13.255 NSW Health also submitted that:

> there are some non-financial benefits that may be associated with the provision of surgical training. These include: personal satisfaction gained from being involved in surgical training; academic recognition and status and access to surgical registrars who could provide direct patient care support to the consultant surgeons working in public hospitals. [333]

13.256 The Commission is unable to form a view on this important issue given the conflicting submissions it has received. That is to say, it is unable to conclude what, if any, percentage of Fellows time in training and supervising trainees, which the College has valued at $216,000,000, is provided on a pro-bono basis.

13.257 However, it seems clear that surgeons do provide the following services on a pro-bono basis:

- assessing the competence of overseas-trained practitioners (although the College has recently significantly increased its fees in this area);
- accrediting hospitals for basic training and hospital posts for advanced training;
- selecting applicants for basic and advanced training;
- conducting and marking exams;
- presenting formal surgical skills courses; and
- presenting out-of-hospital hours lectures and tutorials.

13.258 The College considers that the (conservative) annual value of these services is around $14,000,000.[334]

13.259 In addition, the College includes its annual operating budget attributable to training and assessment activities – $10,500,000 – and the annual running costs of its three surgical skills centres – $2,250,000 – in the value of its pro-bono activities.

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[331] NSW Health submission, April 2002, p12.
[332] ACT Department of Health, Housing and Community Care submission, 13 September 2001, p3.
[333] NSW Health submission, April 2002, p12.
[334] See table 10.1

13.260 However, the College submitted that it – as opposed to College Fellows – collects fees for specified training and assessment services in the order of $5.5 million.[335] For example:

- the total amount of fees payable by first year basic trainees is $8185;
- the total of each of the fees payable by second year basic trainees is $9485;
- all advanced trainees pay an annual training fee of $2185;
- trainees undertaking the Part 2 examination pay a fee of $4680; and
- overseas-trained surgeons assessed by the College pay a fee of at least $4000. The College submitted that these fees:

  > cover reimbursement of Fellows' expenses (travel, accommodation) and administration of the process, as well as any honorarium that may need to be paid for the time expended by Fellows (a rare occurrence). This scheme was developed by the AMC after significant consultation with the Committee of Presidents of Medical Colleges.[338]

13.261 These fees would presumably be used to cover, at least partially, the operating costs of the College and its skills centres, in which case the value of the College's pro-bono claim would need to be correspondingly reduced.

13.262 In conclusion, in its draft determination, the Commission concluded that the value of the College's pro-bono activities is, *at a minimum*, in the order of $20-25 million per annum, being the estimated value of those services provided by the College on a pro bono basis as discussed in paragraphs 13.257 to 13.261. This remains the Commission's view.

13.263 The second issue is then whether the College's pro-bono activities generate a public benefit. The direct beneficiaries are:

- surgical trainees who are relieved of the need to pay fees; and/or
- taxpayers if these hypothetical fees were at least partially publicly subsidised.

13.264 If fees were payable, surgical trainees, upon entering the workforce, would likely seek to recoup these fees by charging higher fees to private patients and seeking higher remuneration from public hospitals. If public hospitals were unwilling or unable to pay this higher remuneration, they would eventually find it difficult to attract surgeons to work for them. Moreover, fewer people may seek to become surgeons, given the size of the public health sector relative to the private.

13.265 Ultimately, governments would likely come under pressure to increase public hospital funding. This would either require tax increases or the switching of public funding from other presumably worthy areas, in both cases to the detriment of the community.

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[335]College submission, 13 March 2003, p17.
[338]College submission, 13 March 2003, p13.

13.266 If surgical tuition fees were publicly subsidised, public funding would need to be taken from other areas.

13.267 Given the above, to the extent that surgical training is provided on a pro-bono basis, it seems clear that this constitutes a public benefit.

13.268 Overall, the Commission accepts that, at a minimum, the College's pro-bono activities generate a public benefit valued at around $20-25 million each year. As indicated above, the Commission is not able, on the basis of the information before it, to assess whether the College's claim that the total value of its pro-bono training and assessment activities is around $230 million per annum is correct.

Possible detriment from providing surgical training and assessment on a pro-bono basis

13.269 It is possible that College Fellows providing training and assessment services on a pro-bono basis generates public detriment. In particular, one limit on the number of basic surgical trainees – and ultimately the number of advanced trainees – is the number of College Fellows who are willing to teach the basic surgical skills courses on a pro-bono basis.

13.270 Similarly, the fact that College Fellows are not paid to assess overseas-trained surgeons could conceivably contribute to delays in undertaking these assessments.

13.271 More generally, concerns about the public accountability and transparency of College training and assessment processes may derive, at least indirectly, from the fact that some of these processes are undertaken on a pro-bono basis. Undertaking these processes on a pro-bono basis might make it more difficult than otherwise for the College to require its Fellows to adhere to formal accountability and transparency requirements.

Other public benefits

13.272 The College also stated that its activities more generally give rise to public benefits. For, example, the College provides for the ongoing retraining and professional development of Fellows through its continuing professional development program. The College and its Fellows also continue to work free of charge on a number of public safety and health initiatives as well as running outreach programs delivering essential surgical services to remote areas within Australian as well as overseas.

13.273 However, in evaluating the College's application, the Commission is required to assess the public benefit and anti-competitive detriment of the specific conduct for which authorisation is sought. The extent of any public benefit (or anti competitive detriment) flowing from other College activities is not relevant to the Commission's assessment of the arrangements for which authorisation is sought.

Weighing up the public benefit and detriment

13.274 It is clear that the College's training and assessment processes are likely to generate public benefits, particularly in the form of maintaining high surgical standards but also because the College provides certain services on a pro-bono basis. The magnitude of this public benefit is likely to be significant.

13.275 However, the potential public detriment from the College's training and assessment

processes is also likely to be significant. Broadly, the Commission considers that:

- surgeons involved in the College's training and assessment processes possess a conflict of interest in that the number of trainee surgeons is likely to affect their future incomes. More generally, their expertise is likely to be limited to surgical practice and techniques;

- College Fellows have the means to restrict entry into surgical practice through the judgement and subjectivity inherent in the College's training and assessment processes; and

- interested parties, and particularly state and territory governments, have raised sufficient concerns about the College to justify a finding that the aforementioned factors create the potential for standards to be set at a level beyond what is necessary to ensure that graduating surgeons are safe and competent, which would disadvantage patients by unjustifiably reducing the affordability and availability of surgery.

13.276 Where it is difficult to precisely determine magnitudes of public benefit and detriment that appear to be of similar size – as is the case with the College's application – there may be some uncertainty about whether the public benefit outweighs the public detriment.

13.277 In these cases, the Commission will generally not be satisfied that the public benefit generated by the application outweighs the anti-competitive detriment. However, it may consider whether it is possible to grant authorisation subject to conditions aimed at reducing, as far as possible, any uncertainty about whether the public benefit is greater than the anti-competitive detriment. These conditions would either seek to increase the public benefit or, more typically, reduce the anti-competitive detriment sufficiently to remove any concern that authorisation was being inappropriately granted. This is what the Commission proposes to do as regards the College's application for authorisation.

Conditions

Accreditation of hospitals for basic surgical training and hospital training posts for advanced surgical training

Accreditation criteria

13.278 As indicated above, currently, the College alone sets the standards which hospitals must meet to be accredited for basic surgical training, as well as the standards which individual hospital posts must meet to be accredited for advanced surgical training.

13.279 Health ministers provided the following views before the Commission issued a draft determination.

13.280 The Commonwealth Minister for Health and Ageing, Senator the Hon Kay Patterson, submitted that, while the Commonwealth supported the College continuing its role in assessing surgical training posts and overseas-trained surgeons:

> I would support in principle the participation of other stakeholders in these processes, including the

possible involvement of health departments.[339]

13.281 The Minister for Health in Victoria, the Hon John Thwaites MP, submitted that:

> The State would support the principle that opportunities for input from other key stakeholders would further assist the College to achieve increased transparency.[340]

13.282 NSW Health submitted that:

> The Department considers that the College is the best placed organisation to make judgements about the suitability of training posts. However, the College should also seek input from external stakeholders, including NSW Health and its specialist committees on medical education and training, when developing or reviewing its accreditation standards.[341]

13.283 The draft determination proposed that the College's accreditation criteria be reviewed by a committee comprising nominees of the AHMC, the College and the AMC in accordance with the following principles:

- the criteria should be such as to ensure that, upon completing their training (including relevant examinations) surgeons are competent;
- except where specifically Australian conditions need to be addressed, the criteria should be broadly consistent with those existing in comparable countries;
- subject to the principles above, the criteria should facilitate training in the widest range of hospitals possible, and particularly in hospitals outside state capital cities;
- the criteria should be as objective as practicable and appropriate subject to the above principles;
- the criteria should be expressed in as reader-friendly a manner as possible;
- criteria should be publicly justified and publicly available; and
- if some criteria are inherently more important than others, this should be explicitly recognised.

13.284 The review team was required to consult with interested parties before issuing a draft report for comment and then a final report.

13.285 The AHMC supports the review. It recognised that there should also be a greater effort to accredit a higher proportion of rural and non-major teaching hospital posts.[342] However, it proposed several changes to the terms of reference of the review including:

- that there be an independent secretariat to the review;

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[339]Submission from Commonwealth Minister for Health and Ageing, Senator the Hon Kay Patterson, 8 October 2002, p1.
[340]Submission from Victorian Minister for Health, the Hon John Thwaites, 3 October 2002, p1.
[341]NSW Health submission, April 2002, paragraph 5.1.18.
[342]AHMC submission, 25 June 2002, p7

- that a draft report be required within six months and a final report within nine months;
- that a draft final report be presented to the College for comment on implementation issues;
- that if for exceptional reasons the College considers that it is unable to implement any of the recommendations, it should be required to advise the Commission within one month; and
- the review should consider the feasibility of accrediting hospitals rather than hospital posts for advanced surgical training.[343]

13.286 The College, in its response to the draft determination, proposed that the recent AMC review of the College substitute for the proposed review.[345] However, it considered that if the Commission were to determine that a further review was appropriate, it considered that:

- the timeframe for the review should be extended to 9 months (from the 6 months proposed by the Commission);
- state and territory health departments should bear the total cost of the review so as to ensure its independence;
- the proposed review team of three members is too small; and
- that the College should only be required to implement the review recommendations if they are able to be implemented and are feasible in terms of resource allocation. In addition, it submitted that the College should not be able to unreasonably refuse to implement a recommendation.[346]

13.287 The College also submitted that:

> it is currently considering the proposition to accredit hospitals (rather than individual posts in hospitals) for advanced surgical training. Whether this will create more accredited positions is debatable. There are however other advantages – cost, time and better articulation of training opportunities. The College will also need to be mindful of the difference between the different exposure required of basic and advanced surgical training candidates. For example, the involvement in operative procedures is of such importance to the advanced surgical training process that the College needs to be assured that every trainee will receive an exposure which at least meets the agreed minimum.[347]

13.288 Dr Mark Shanahan, a retired eminent cardio-thoracic surgeon noted that in some instances the quality of on-the-job training received by trainees in non-accredited advanced training positions is not dissimilar, and in some instances may even be of a higher quality, than that received by a trainee in a similar, accredited post.[348]

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[343]Ibid .
[345]College submission, 13 March 2003, p22.
[346]College submission, 3 June 2003, pp3-5.
[347]College submission, 13 March 2003, p20
[348]Submission from Dr Mark Shanahan, 13 March 2003.

13.289 Dr Shanahan contended that where training in a non-accredited post can be demonstrated as being sufficient, this training should be recognised retrospectively by the College. Dr Shanahan noted that this would require trainees occupying non-accredited posts to maintain the appropriate records in order to demonstrate to the College the level of training experienced.[349]

13.290 The Commission considers that the proposed review remains necessary. It does not consider that the AMC review would constitute an adequate substitute. It has however, amended the terms of reference for the review to include most of the proposals put forward by the AHMC, the College and interested parties. The main exceptions are:

- rather than allow the College not to implement review recommendations in exceptional circumstances or if it considers they are not feasible, the College will not be required to implement a review finding if it can obtain the agreement of a majority of health ministers;

- as regards the proposal that health departments fund the review, the Commission is unable to require this. However, to minimise any perception that the review might be biased towards the College or towards health departments, the Commission strongly supports the College and health departments each contributing half the cost of the review.

13.291 The Commission considers that requiring the review to examine whether training in non-accredited posts can be retrospectively accredited is an important short-term measure to address the shortage of surgeons.

13.292 Consequently, the Commission imposes the following condition addressing the College's exclusive role in setting the standards for accrediting hospitals and hospital posts.

C1: In accordance with the terms of reference at Attachment D, the College is required to establish a public independent review of the criteria for accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training and associated matters.

Accreditation teams

13.293 The following views were provided before the Commission issued a draft determination. The South Australian Minister for Health, the Hon Lea Stevens MP, submitted that:

> the accreditation by the RACS of training posts without consultation with the DHS is also not acceptable given the responsibilities for the distribution, funding and provision of services that this Government has.[350]

13.294 Queensland Health suggested that:

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[349] Ibid.

[350] Submission from South Australian Health Minister, the Hon Lea Stevens, 11 September 2002, p2.

> the objectivity and external scrutiny of the [accreditation] process could be enhanced by the inclusion on the team of a member who has no connection with either the hospital (and health department) or the College.[351]

13.295 In its draft determination, the Commission broadly proposed that nominees of health ministers be added to College accreditation teams. In its response to the draft, the AHMC supported this proposal.[352] The College indicated it was able to comply with the proposal.[353]

13.296 Generally, the Commission considers that the addition of representatives of the health minister to the teams assessing hospitals and hospital posts will assist in ensuring that the Commission, governments, doctors and the public can be confident that the accreditation criteria are being applied in a fair and reasonable manner over the term of the authorisation. In particular, while health minister representatives would not necessarily be health department officials – for example, they could be representatives of consumer groups – they could be expected to have the considerable resources and knowledge of the health department to assist them to contribute to the team's deliberations.

13.297 The Commission imposes the following condition:

> **C2: Within one month of authorisation commencing, the College shall invite the health minister in each state or territory to nominate persons to participate in the assessment of hospitals (for basic surgical training) and hospital training posts (for advanced surgical training) in that minister's state or territory. The College shall ensure that, if the health minister nominates members, each team established to assess a hospital or hospital posts in that state or territory includes a member nominated by the minister.**

13.298 The administrative processes underlying this condition are addressed in condition C19.

Ensuring all possible hospital posts are considered for accreditation

13.299 As indicated above, it appears to the Commission that College Fellows have significant control over the process for applying for accreditation for hospitals for basic surgical training and for hospital posts for advanced surgical training. Further, it appears that there is a large degree of uncertainty regarding why some hospital posts are accredited, or at least considered for accreditation, and other seemingly identical posts are not.

13.300 In its draft determination, the Commission broadly proposed that the College write to health ministers seeking nominations for hospitals (for basic training) and hospital posts (for advanced training) to be accredited. In its response to the draft, the AHMC supported this proposal.[354] The College indicated it was able to comply with the

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[351] Queensland Health submission, 4 May 2001, p3.
[352] AHMC submission, 25 June 2003, p8.
[353] College submission, 3 June 2003, p5.
[354] AHMC submission, 25 June 2003, p8.

proposal.[355] In fact, it submitted that it had already written to Ministers seeking their responses in anticipation of the 2003 selection processes. It also sought:

> assurances from Ministers that they can commit funding for hospital training posts in advance so that the College can select trainees for posts with confidence that they will be funded. [356]

13.301 The College also noted that:

> In the case of basic surgical training, this approach may have unintended consequences. There are a number of suitable rural and urban district/community hospitals which might wish to seek such accreditation and may well be able to satisfy the requirements. However, there would be significant ramifications if such hospitals were to devote resources to trainees and supervisors but then be unable to attract trainees. The College may then have to consider playing a more influential role in the appointment of basic surgical trainees to hospital posts, as is the case with the advanced surgical training programme.[357]

13.302 Given the general support for the position in the draft determination, the Commission imposes the following condition, which addresses concerns that there exist non-accredited posts that would be suitable for accreditation.

> **C3: Within one month of the accreditation criteria resulting from the review specified in Condition C1 being implemented, and at least annually thereafter, the College shall write to state and territory health ministers requesting that they nominate any hospitals for basic surgical training and/or hospital training posts for advanced surgical training for which they wish to seek accreditation.**

13.303 The administrative processes underlying this condition are addressed in condition C19.

General transparency

13.304 The following condition assists in ensuring procedural fairness and public transparency in the accreditation process, which will assist in ensuring that the public benefit from this process outweighs the public detriment over the term of the authorisation.

> **C4: The College shall:**
>
> - **continue to advise the applicant – that is, health departments, area health services or individual hospitals, as the case may be – as to decisions on the accreditation of hospitals for basic surgical training and hospital training posts (or hospitals[358]) for advanced surgical training in writing within six months;**
>
> - **continue to provide written reasons for decisions and advise applicants of their appeal rights;**

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[355] College submission, 13 March 2003, p23.
[356] College submission, 3 June 2003, p6.
[357] Ibid.
[358] This recognises that the College may commence accrediting hospitals rather than hospital posts for advanced surgical training as a result of the review imposed by condition C1.

- **continue to complete re-assessments of hospitals for basic surgical training and hospital training posts (or hospitals) for advanced surgical training before their existing accreditation expires;**

- **annually publish:**

  - **the number of requests for accreditation of hospitals for basic surgical training and hospital training posts (or hospitals) for advanced surgical training by specialty and hospital;**

  - **the number of re-assessments of existing advanced surgical training posts (or hospitals) by specialty and hospital and the number of re-assessments of hospitals for basic surgical training;**

  - **the number of advanced surgical training posts (or hospitals) granted accreditation or re-accreditation and the number of advanced surgical training posts (or hospitals) not accredited or granted re-accreditation;**

  - **the number of hospitals granted accreditation for basic surgical training and the number of hospitals denied accreditation;**

  - **the basis on which accreditation was not granted specifying which standards the hospital or post did not meet;**

  - **the number of assessments completed in less than six months; and the number of assessments completed in more than six months;**

  - **the number, if any, of reassessments not completed before the expiry of existing accreditation;**

  - **the number of appeals lodged and the appeal results; and**

  - **a description of the assessment process.**

13.305 The AHMC supported a proposed condition in nearly identical terms in the draft determination.[359]

13.306 In response to that proposed condition, the College submitted that it:

> already advises hospitals of the outcome of accreditation of hospital training posts for advanced surgical training by supplying hospitals with a copy of the inspection report and giving them the opportunity to respond...
>
> The College already complies with this Condition for hospital training posts according to its quinquennial plan.
>
> With regard to the assessment and re-assessment of hospitals for basic surgical training the College acknowledges that its accreditation protocols are less advanced. While the College has commenced developing more advanced protocols for assessment and re-assessment which would comply with this

[359] AHMC submission, 25 June 2003, pp8-9.

Condition it is reluctant to progress this further until such time as the Commission's attitude on the review of the criteria for accrediting hospitals is known.[360]

Assessment of overseas-trained surgeons

13.307 The Commission understands that, in broad terms, the point of requiring medical specialist colleges to assess overseas-trained medical specialists is to ensure that only those specialists who are competent and safe are permitted to practise in Australia.

Assessment criteria

13.308 The draft determination proposed that the College issue public guidelines setting out how it determines whether overseas-trained surgeons are equivalent to Australian surgeons. These guidelines were to be developed by a committee comprising nominees of the AHMC, the College and the AMC.

13.309 The AHMC supported this condition subject to largely the same concerns it raised in relation to the review of the College's accreditation criteria (see paragraph 13.285). However, it also proposed that the terms of reference for the review:

include consideration of whether equivalence, substantial comparability or some other test is the preferable test, and a determination of the appropriate test and processes for assessing overseas-trained surgeons in each of the following categories:

- assessment of an overseas trained surgeon who is seeking full registration to practise as a specialist in Australia.
- assessment of an overseas trained surgeon who is seeking conditional registration to practise within a limited area of specialisation or subspecialty practice.
- assessment of an overseas trained surgeon who is seeking registration to practise in an area of need, and whose practice is limited by conditional registration to a specific role that is determined by the job description for the position.[361]

13.310 The AHMC also submitted that:

The tests used to assess overseas-trained surgeons need to satisfy the relevant registration provisions of the Medical Practitioner Registration legislation in each jurisdiction. Accordingly, any changes to the test recommended by the review should be referred to the AHMAC Working Party To Consider A Draft Model For A Nationally Consistent Approach To Medical Registration, where this matter can be considered, particularly in relation to categories of registration.

For surgeons that are well qualified and experienced, the need for and level of supervision is variable and this issue should be included in the review committee's terms of reference. For surgeons assessed by the College as requiring additional training, the review process needs to consider how processes can be implemented that allow surgeons to train and gain equivalence that is tailored to the requirements of their individual skills and experience, and not simply related to time service or fitting into the requirements of the existing training program for local graduates.[362]

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[360]College submission, 3 June 2003, pp7-8.
[361]AHMC submission, 25 June 2003, pp10-11.
[362]Ibid.

13.311 The College raised largely the same concerns about this proposed condition as it did in relation to the proposed review of its accreditation criteria (see paragraph 13.286).[363]

13.312 More generally, Hunter Health submitted that

> Many [overseas-trained surgeons] have good qualifications from respected Colleges or Boards and are therefore offended when asked to submit to supervision and/or sitting of further exams. It does not seem logical to say it is acceptable for Australian fellows to seek post graduate training with doctors trained in these overseas programs, but not accept graduates from the same programs as having at least equivalent qualifications to Australian fellows. Indeed, it is paradoxical that surgeons who have trained Australian fellows in nations such as the UK and USA would be required to sit for exams if they wish to practise in Australia.
>
> Highly qualified overseas surgeons may be prepared to submit their CVs for assessment and to undergo a formal assessment, for example, after one year, but this needs to be fair and reasonable and not couched in terms that suggest their training is inadequate...
>
> it should be possible to assess the quality of overseas medical and surgical training programs and determine which ones are of equally high quality to the Australian program. Such programs should be "pre-qualified" by the College. Much of the bureaucracy surrounding the assessment and registration of overseas trained doctors could then be avoided: doctors who were suitably qualified from a program deemed to be "equivalent" to Australian training would not be required to undergo lengthy individual assessment processes.[364]

13.313 In response, the College submitted that:

> automatic exemption from advanced surgical training carries with it inherent, unacceptable risks and it is therefore important that each overseas trained practitioner is assessed on the basis of his or her individual skills and experience.[365]

13.314 The Commission considers that the proposed review remains necessary. It has however, amended the terms of reference for the review to include most of the proposals put forward by the AHMC, the College and interested parties. The main exceptions are:

- that the College will not be required to implement any aspect of the guidelines if it can obtain the agreement of a majority of health ministers;
- the Commission is unable to require health departments to contribute to the cost of the review. However, to minimise any perception that the review might be biased towards the College or towards health departments, the Commission strongly supports the College and health departments each contributing half the cost of the review.

13.315 The review will examine whether persons who have completed particular overseas training programs could be automatically exempted from being required to undertake advanced surgical training (the College already exempts persons holding specific qualifications from basic surgical training). In addition, the review will examine, if such programs are found to exist, what if any requirements should be imposed to

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[363] Except as regards the possibility that the AMC's recent accreditation review of the College could substitute for the proposed review.
[364] Hunter Health submission, 30 March 2003, p9
[365] College submission, 3 June 2003, p9.

allow an assessment of the relevant surgeons' abilities in practice. Generally, the Commission is sympathetic to the view expressed by Hunter Health.

13.316 The Commission therefore imposes the following condition.

C5: In accordance with the terms of reference at Attachment E, the College shall establish an independent committee to publicly assess whether the test that specialist medical colleges use to asses overseas trained surgeons should be equivalence, substantial comparability, competence or some other test, including in relation to:

- **the assessment of an overseas trained surgeon who is seeking full registration to practise as a specialist in Australia;**
- **the assessment of an overseas trained surgeon who is seeking conditional registration to practise within a limited area of specialisation or subspecialty practice; and**
- **the assessment of an overseas trained surgeon who is seeking registration to practise in an area of need, and whose practice is limited by conditional registration to a specific role that is determined by the job description for the position.**

In accordance with Attachment E, the College shall prepare public guidelines on how it applies the test for assessing overseas-trained surgeons.

Assessment teams

13.317 The following views were provided before the Commission issued a draft determination. NSW Health submitted that:

> the membership of the assessment panel [for overseas-trained surgeons] should be broadened to include representation from the employer and consideration should be given to including an independent lay member. For example, in considering candidates for rural Area-of-Need specialist positions, the assessment panel should where practicable include a rural specialist who is familiar with the requirements of rural surgical practice. The Department contends that opening up the process would increase the public benefit by increasing stakeholder (overseas-trained doctors, employers and the community) confidence in the system.[367]

13.318 The draft determination, in broad terms, proposed that health minister nominees be included in teams assessing overseas-trained surgeons. The AHMC supported this condition.[368] The College indicated that it was able to comply with the condition.[369] However, it noted that:

> Assessment of an overseas-trained surgeon involves reviewing significant amounts of documentary evidence and conducting an interview. On average approximately 60 interview assessments are likely to occur in any given year.

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[367]NSW Health submission, April 2002, paragraph 6.2.2.
[368]AHMC submission, 25 June 2003, p11.
[369]College submission, 3 June 2003, p10.

> The College is concerned that the inclusion of such nominees in the assessment teams may impact on the time-lines of the assessment process, and consequently on the College's ability to comply with Condition 7 (see below).[370]

13.319 Condition 7 in the draft determination imposed a six month time-limit on College assessments.

13.320 In light of the above, the Commission remains of the view that the addition of representatives of the health minister to assessment teams would ensure that the Commission, governments, doctors and the public can be confident that the assessment test is being applied in a fair and reasonable manner over the term of the authorisation.

C6: Within one month of authorisation commencing, the College shall invite the health minister in each state or territory (or delegate) to nominate persons to participate in the assessment of overseas-trained surgeons.

If nominations are made, the College shall ensure that each team formed to assess an overseas-trained surgeon includes a person nominated by the health minister (or delegate) for the state or territory which is the most relevant in the circumstances (for example, the state or territory where the overseas-trained surgeon resides or wishes to work).

13.321 The administrative processes underlying this condition are addressed in condition C19.

Procedural fairness – timeframes for assessing overseas-trained surgeons, reasons and appeal rights

13.322 The time taken by the College to complete assessments of overseas-trained surgeons is a concern of many interested parties.

13.323 In its draft determination the Commission proposed that the College inform overseas-trained surgeons of the result of the outcome of their assessment within six months.

13.324 In response, the College submitted that it could comply with this proposed condition, and that it:

> already endeavours to meet the AMC's recommended timeframe of three months.[371]

13.325 The AHMC considered that, where a state or territory medical board requests an assessment from the College, that AMC timeframes should apply, including the 8 week timeframe for the assessment of overseas-trained surgeons seeking to work in areas-of-need.[372]

13.326 The Commission also considers it appropriate on procedural fairness grounds that overseas-trained surgeons who are not assessed as meeting the relevant test – currently whether they are equivalent to Australian-trained surgeons – are provided with written reasons for this decision and advised of their appeal rights.

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[370] Ibid.
[371] College submission, 13 March 2003, p26.
[372] AHMC submission, 25 June 2003, p11.

13.327 In light of this, the Commission imposes the following condition.

C7: The College shall inform overseas-trained surgeons intending to work in an area of need of the outcome of its assessment within eight weeks and otherwise within three months. The eight-week and three-month periods shall commence when the College receives all information required from the overseas-trained surgeon concerned. The College shall provide written reasons to all overseas-trained surgeons whom it assesses as not being equivalent to an Australian-trained surgeon and shall advise these surgeons of their appeal rights.

Overseas-trained surgeons who have already been assessed by the College

13.328 The Commission considers that an important short-term measure to address the shortage of Australian surgeons (see paragraphs 14.6) is for the College to re-assess – in accordance with the processes as altered by the conditions of this authorisation – overseas-trained surgeons it has previously assessed and who were not found to be equivalent to Australian-trained surgeons.

C8: If requested, the College shall re-assess any overseas-trained surgeon it assessed and found not to be equivalent to an Australian-trained surgeon or was in the process of assessing prior to the implementation of the interim guidelines required under condition C5.

General transparency

13.329 To assist in ensuring that the College's processes for assessing overseas-trained surgeons are publicly transparent, the following condition is imposed.

C9: The College shall annually publish:

- **the number of applications received for assessments of overseas-trained surgeons other than in areas-of-need;**
- **the number of applications received for assessments of overseas-trained surgeons to work in areas-of-need;**
- **the number of assessments of overseas-trained surgeons seeking to work in areas-of-need completed;**
- **the number of assessments of overseas-trained surgeons other than those seeking to work in areas-of-need completed;**
- **the number of assessments of overseas-trained surgeons not seeking to work in areas-of-need completed in three months or less and the number of assessments completed in more than three months;**
- **the number of assessments of overseas-trained surgeons seeking to work in areas-of-need completed in eight weeks or less and the number of assessments completed in more than eight weeks;**

- **the number of assessments where overseas-trained surgeons were required to complete basic and advanced surgical training;**

- **the number of assessments where overseas-trained surgeons were required to complete advanced surgical training only;**

- **the number of assessments where overseas-trained surgeons were required to complete a period of supervised work;**

- **the number of overseas trained surgeons assessed for conditional registration on behalf of the AMC;**

- **the number of overseas trained surgeons assessed as requiring two or less years training to meet College equivalence;**

- **the number of overseas trained surgeons undertaking and/or completing training as specified by the College; and**

- **the outcome of any other assessments.**

Information sought by each of the above dot points shall be broken down into the following categories:

- **applicants with original qualifications from an English speaking country;**

- **applicants with original qualifications from a non-English speaking country but with further qualifications from an English speaking country;**

- **applicants with qualifications only from a non-English speaking country.**

The College shall also publish annually a description of the assessment process (to the extent that the College does not do this already – for example, on its internet website).

13.330 The Commission proposed a condition in similar terms in its draft determination.

13.331 The College advised that it was able to comply with the proposed condition and noted that to the extent that the required information is not already included in its annual report, it will incorporate it into future annual reports.[374]

13.332 The AHMC supported the proposed condition with some additions. The AHMC also supported the publication of information on overseas-trained doctors according to whether the language in which medical education was received was English, another language or a combination.[375]

13.333 The Australian Doctors Trained Overseas Association also submitted that information on overseas-trained doctors should be broken down into the following groups:

- those with original qualifications from an English-speaking country;

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[374]College submission, 13 March 2003, p26
[375] AHMC submission, 25 June 2003, p12.

- those with original qualifications from a non-English speaking country but with further qualifications from an English-speaking country;
- those with qualifications only from a non-English speaking country.[376]

Selection of trainees

13.334 Generally, the Commission supports the implementation of the Brennan national best-practice trainee selection principles by specialist medical colleges, particularly given the subjectivity inherent in many of the selection criteria used by the College.

13.335 The Brennan principles include:

- that there exist clear and public selection criteria for selecting trainees, as well as clear and public criteria that trainees must meet to be eligible to apply;
- that limits on the number of training posts be openly declared;
- that interviews should be objective and free of bias;
- that referees' reports should be pro-forma;
- that candidates should be offered a frank appraisal of their standing by the selection committee; and
- that decisions of the selection committee be documented and appealable.[377]

13.336 In particular, the Commission considers that implementation of these principles would assist to ensure that the public can be confident that the public benefit from the College's selection processes will outweigh any potential public detriment from these processes over the term of the authorisation.

13.337 The criteria used by the College for selecting entrants into basic and advanced surgical training include:

- undergraduate academic performance and, for advanced training, performance in basic surgical training;
- the ability to interact effectively and affably with peers, mentors, members of the health care team, patients and their families;
- the ability to contribute effectively as a member of a health care team;
- the ability to perform realistic self-assessment; and
- effective spoken communication.

13.338 In its submission prior to the draft determination NSW Health acknowledged:

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[376] Australian Doctors Trained Overseas Association submission, 13 February 2003, p2.
[377] See Attachment F of this determination.

> the College's recent efforts to implement the [Brennan] national best-practice trainee selection framework and self regulate procedures in line with current human resources practice...
>
> The Department supports the inclusion of independent members on selection panels... There is also the issue of employer (hospital management) representation on the selection committee given that the trainees are also being appointed to service positions as employees of the [area health service]. At the present time, there is usually one medical administrator on each advanced training selection committee. However, as the College has moved towards state or national selection processes for advanced surgical training positions, the issue of adequate employer representation becomes problematic as one selection process results in appointments to many AHS and hospitals.[378]

13.339 The draft determination, in broad terms, proposed that the College ensure that its selection processes were consistent with the Brennan principles (to the extent they were not already) and invited health ministers to nominate members to selection teams. The draft determination also required the College to provide written reasons to all unsuccessful applicants.

13.340 In response, the College submitted that the AMC had confirmed that it had met the Brennan principles. Further, it is able to comply with the condition regarding health minister nominees participating in selection panels. It noted that selection panels would meet around 50 times a year.[379]

13.341 The College further emphasised that:

> the selection of trainees, particularly into advanced surgical training, relies on technical expertise and it will be difficult for a lay member of a panel to participate meaningfully in the selection process. This is recognised by jurisdictions, who have undertaken to ensure that appropriately qualified nominees are selected... the inclusion of such nominees, particularly if they participate actively in the selection process, may have an impact on the timeliness of the selection process...[380]

13.342 In its draft determination, the Commission proposed a condition that the College be required to provide written reasons to all unsuccessful applicants for basic and advanced surgical training.

13.343 In response the College submitted that:

> the condition would place an unnecessary and onerous burden on the College due to the large number of applicants with whom it would need to correspond. In addition, it is possible to have several qualified candidates for a remaining place who can only be distinguished by their relative ranking – it would not be possible in such cases to give any other explanation for their non-selection...
>
> The College confirms it view that its current process is adequate. Applicants for basic training are provided with individualised feedback in the form of a quartile ranking for the total selection score and for each individual component. Applicants are also advised to seek further discussion with their supervisors. Trainees who are unsuccessful in obtaining a position in their preferred advanced surgical training program are advised in writing that feedback and counsel is available. There is some variation across specialties as to how this is done, some as face to face interviews, others by phone.[381]

13.344 The College submitted that there should be no need to provide written reasons to unsuccessful applicants provided the following three conditions are met:

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[378]NSW Health submission, April 2002, pp5-6.
[379]College submission, 3 June 2003, pp13-14.
[380]Ibid, p14.
[381]Ibid, p15.

- the information disclosure requirements under condition 10 of the Commission draft determination (for example the publishing of cut off scores for selection into training programs) are met;

- an expert external person, as required by condition 9 of the draft determination, is appointed to each selection panel; and

- the College advises unsuccessful applicants that feedback is available.[382]

13.345 The College also noted that unsuccessful applicants also have a right of appeal to the College's appeals committee and that at the conclusion of the appeals process the parties are provided with written reasons for the decision.[383]

13.346 The AHMC supported the proposed condition with the exception of the proposal to require the College to provide written reasons to unsuccessful applicants.[384]

13.347 The Commission notes the College's concerns that requiring that written reasons be provided to all unsuccessful applicants may be onerous. It also notes that in many instances the reason an applicant has not been successful is simply due to their ranking relative to other applicants rather than that they were unsuitable for the position. Despite this, the Commission remains of the view that the feedback provided to applicants for surgical training is unnecessarily limited.

13.348 For example, providing applicants for basic surgical training with their decile[387] ranking for their total selection score and each individual component, along with the cut off score for admission to the program, and the decile into which the lowest ranked applicant accepted into the program fell (addressed in condition C10) would provide candidates with a much better indication of their performance relative to other applicants, and relative to the cut off for admission, than does a quartile ranking.

13.349 While unsuccessful applicants for advanced surgical training are provided with greater opportunities to receive feedback than are applicants for basic surgical training, they are not, unlike unsuccessful applicants for basic surgical training, advised of whether the selection panel considered them as suitable for admission to the advanced surgical training program. The Commission considers that unsuccessful applicants for advanced surgical training should be provided with this information.

13.350 In light of the above, the Commission imposes the following condition:

C10: The College shall ensure that its selection processes for basic and advanced surgical training continue to be consistent with the Brennan principles (as set out in Attachment F).

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[382] Ibid.
[383] Ibid.
[384] AHMC submission, 25 June 2003, p13.
[387] For example, top 10% of score distribution, between 90% and 80% of score distribution, between 80% and 70% of score distribution, etc.

Within one month of authorisation commencing, the College shall invite health ministers to nominate members to all panels (whether national or regional) selecting trainees for basic and advanced surgical training.

The College shall provide all applicants for basic surgical training with their decile ranking for their total selection score and for each individual component of their assessment.

The College should advise all unsuccessful applicants for advanced surgical training as to whether they were suitable for admission to the advanced surgical training program.

Finally, the College should provide written reasons to all unsuccessful applicants for basic surgical training and advanced surgical training if requested by these applicants.

13.351 The administrative processes underlying this condition are addressed in condition C19.

13.352 As with similar conditions above, the addition of representatives of health ministers to selection committees and interview panels aims to ensure that the Commission, governments, doctors (particularly applicants for surgical training) and the public can be confident that the selection criteria are being applied in a fair and reasonable manner over the term of the authorisation.

General transparency

13.353 The following condition is intended to assist in ensuring that the net public benefit generated by the College's selection processes will continue during the term of the authorisation by ensuring that these processes are publicly transparent.

C11: The College shall make public annually:

- **the number of applicants for basic surgical training;**
- **the number of successful applicants for basic surgical training;**
- **the 'cut-off' score for basic surgical training (that is, the score below which applicants would not be eligible to enter training);**
- **the decile in which the lowest-ranked applicant accepted into basic surgical training fell;**
- **the number of basic trainees who have been appointed by individual hospitals;**
- **a statement of the criteria for, and a description of the process for selecting basic surgical trainees;**
- **the number of applicants for advanced training;**
- **the number of successful applicants for advanced surgical training;**

- **the 'cut-off' score for advanced surgical training;**
- **the number of advanced surgical training posts available by sub-specialty and hospital;**
- **the number of unfilled advanced (accredited) surgical training posts by sub-specialty (if any) and an explanation as to why in each case; and**
- **a statement of the criteria for, and a description of the process (including the weight given to each element of the process) for selecting advanced surgical trainees in each sub-specialty.**

13.354 The Commission proposed an almost identical condition in its draft determination. The AHMC supported the proposed condition.[388] The College largely supported the proposed condition and indicated that, to the extent that the information was not already there, the required information would be provided in its annual report or on its website.[389]

Limit on the number of basic surgical training posts

13.355 As indicated at paragraphs 13.198-212, limiting the number of basic surgical training posts has some merit, particularly in helping to ensure that the time and resources expended on basic training are not wasted where trainees are unable to win a place in advanced training. On the other hand, this limit may result in advanced surgical training posts not being filled. It may also negatively impact on hospital employment.

13.356 In its draft determination, the Commission proposed in broad terms that the College consult with health ministers before determining the number and distribution of basic surgical training posts each year.

13.357 In response, the College stated that was largely able to comply with the proposed condition. The AHMC supported the proposed condition.[390]

13.358 The following condition aims to ensure that the potential for public detriment to arise from limiting the number of basic surgical training places is minimised.

C12: Before finalising the limit on the number of basic surgical training posts for a particular year, and the distribution of these posts between states and territories, the College shall write to Commonwealth, state and territory health ministers:

- **informing them of the limit it proposes to impose on the number of basic surgical training posts for the following year;**
- **explaining how this proposed limit has been calculated;**
- **informing ministers of the proposed distribution of basic surgical training posts by state and territory;**

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[388] AHMC submission, 25 June 2003, p15.
[389] College submission, 3 June 2003, p16.
[390] The AHMC submission to the Commission, 25 June 2003, p14.

- **explaining how this distribution has been determined; and**

- **inviting ministers to comment on the proposed limit on and distribution of basic surgical training posts within a reasonable specified period determined by the College, and take these comments into account when finalising the limit and distribution.**

13.359 The administrative processes underlying this condition are addressed in condition C19.

Training and examination

13.360 The following condition is intended to assist in ensuring that the net public benefit generated by the College's selection processes will continue during the term of the authorisation by ensuring that these processes are publicly transparent.

C13: The College shall make public annually:

- **the number of basic surgical trainees in each year of training;**

- **the number of trainees successfully completing basic surgical training (and who therefore become eligible to apply for an advanced training position) and the number of these trainees who are in their second year of training, their third year of training and their fourth year of training;**

- **the pass rate for the MSQ and OSCE exams each time they are held;**

- **the number of advanced surgical trainees by sub-specialty and year of training;**

- **the number of trainees approved and not approved to undertake the Part 2 exam by sub-specialty;**

- **the pass-rate for the Part 2 exam by sub-specialty;**

- **the number of trainees successfully completing advanced surgical training by sub-specialty;**

- **the number of new College Fellows by sub-specialty; and**

- **the number of trainees dismissed from basic and advanced surgical training by sub-specialty and the year of the course these trainees were in when dismissed.**

The information required to be published in relation to each of the above dot points shall be published as both a national aggregate and by state or territory.

The College shall also make publicly available (to the extent that it does not already – for example, on its internet website) a summary of basic surgical training and advanced surgical training conducted in each year containing:

- **the length of basic surgical training;**
- **a brief description of the subject matters covered in basic surgical training;**
- **a description of the educational courses required to be completed by basic surgical trainees;**
- **how basic surgical trainees are assessed during their basic training;**
- **a description of the Part 1 examination, including its various elements and the marking system used;**
- **the length of the training courses in each advanced training sub-specialty;**
- **a brief description of the subject matters of the training course in each sub-specialty;**
- **how advanced surgical trainees are assessed during their surgical training;**
- **the criteria used to determine whether a surgical trainee is eligible to sit the Part 2 exam in each sub-specialty; and**
- **a description of the Part 2 examination, outlining its various elements and the marking system used.**

13.361 The Commission proposed a largely identical condition in its draft determination. The AHMC supported the proposed condition but considered that the information should be provided on a national basis and on a jurisdictional basis where relevant.[392] The College stated that it was able to comply with the condition. Most of the information in the latter section of the proposed condition was already publicly available.[393]

Specialist societies

13.362 As indicated at paragraphs 13.180-184, the Commission is concerned that the involvement of the independent specialist societies in particular training programs without any apparent formal relationship between them and the College would create some uncertainty about the ability of the College to ensure that the training programs are administered appropriately. In particular, considerable uncertainty would arise about whether the training programs were being administered in a way that ensures that the public benefit they generate continues to outweigh the public detriment over the term of the authorisation.

13.363 The Commission's draft determination required the College to enter into agreements with each sub-specialty society.

13.364 In response, the AHMC submitted that:

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[392]AHMC submission, 25 June 2003, p16.
[393]College submission, 3 June 2003, pp17-18.

> Health Ministers have a significant interest in being aware of the nature of those relationships as documented in MOUs and service agreements between the College and the societies, and in how the specialty societies will themselves deliver on the proposed conditions.
>
> The College has supplied a written undertaking to provide copies of service agreements.
>
> While the condition is supported, it is proposed that Health Ministers have an opportunity to comment on the service agreements before they are finalised.
>
> This issue will be progressed in the MOUs to be developed with the College, including Health Ministers receiving advice on any changes in these arrangements and how any obligations are being met.[394]

13.365 The College submitted that it has already entered into memoranda of understanding with each relevant specialist society. However, it considered that allowing health ministers an opportunity to comment on the draft service agreements:

> would jeopardise complex negotiations which have been underway for some time.[395]

13.366 In light of the above, the Commission imposes the following condition.

> **C14: Sub-specialty societies involved in advanced surgical training shall act in accordance with College directions relating to advanced surgical training. The College shall also remain party to agreements with each sub-specialty society involved in advanced surgical training specifying the relationship, obligations, responsibilities and accountabilities of that society to the College. These agreements shall specify appropriate mechanisms for ensuring that the College exercises full direction and control over affiliated sub-specialty societies in relation to surgical training. These agreements shall be publicly available (except as regards any financial matters which are reasonably deemed to be commercial-in-confidence).**

13.367 The Commission will review the effectiveness of these agreements when authorisation expires.

Appeals

13.368 The subjectivity inherent in the College's training and assessment processes provides College Fellows with significant discretion when making training and assessment decisions. Consequently, the potential for errors to be made is significantly greater than where purely objective criteria exist. The need for an effective appeals process is therefore also significantly greater.

13.369 This need is heightened by concerns raised with the Commission that College processes, for whatever reason, are not always adhered to. For example, in relation to the assessment of overseas trained surgeons, NSW Health submitted that:

> The College's submission provides details of a fair and thorough assessment process for overseas-trained specialists. However, the experiences of some [area health services] are that the process is either not followed or inconsistently applied.[396]

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[394] AHMC submission, 25 June 2003, p16.
[395] College submission, 3 June 2003, p19.
[396] NSW Health submission, April 2002, p10.

13.370 In addition, concerns were raised with the Commission about the College's recent assessment of a certain advanced general surgical training post. The inspection team report raised concerns about the quality of training in the posts and recommended that accreditation be removed if further concerns arose. The hospital's broad concern was that it was given insufficient opportunity to defend the matters raised against it. For example, it was alleged that, contrary to the College's documented processes, key hospital personnel were not interviewed and that the hospital was not provided with a copy of the draft inspection report for comment. More generally, the College's process for addressing any 'further concerns' arising was unclear.

13.371 It is not for the Commission to draw conclusions on the merits of the concerns raised about the assessment of this training post or the College's response. However, the matter does highlight the need for robust and independent appeals processes.

13.372 Two key issues arise in relation to the College's appeals process:

- the composition of the committee; and
- the need for procedural fairness.

Composition of appeals committee

13.373 The College's Appeals Committee consists of three College Fellows (a Vice President or Councillor and two Fellows from surgical sub-specialties other than the one from which the appeal originates) and two persons who are not College Fellows, one of whom chairs the Committee.

13.374 In its draft determination, the Commission, in broad terms, proposed that the appeals committee be composed of three members nominated by the AHMC and two College Fellows from specialties other than the one from which the appeal originated.

13.375 In response, the College expressed its:

> reluctance to replace its current external members with nominees of AHMAC. The Chairman of the Appeals Committee since its inception has been Emeritus Professor Louis Waller and the other external member is Mrs Mary Murdoch. Professor Waller was the Victorian Law Reform Commissioner and the Foundation Sir Leo Cussen Professor of Law at Monash University. The College continues to be concerned that this change may reduce the ability of the Appeals Committee to propose changes to the College's processes because the new structure would not have the continuity required for this level of activity. The Appeals Committee has gained a wealth of knowledge and experience in dealing with appeals which the College would be reluctant to lose.[400]

13.376 The College therefore submitted an alternative proposal involving:

> the College providing the representatives of the Ministers with a list of six or more nominees from which the Ministers would select a panel of members who would be eligible to serve for a period of five years. The Appeals Committee would continue to be made up of the same group of people as far as possible to provide continuity.[401]

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[400]College submission, 3 June 2003, p31.
[401]Ibid.

13.377 The AHMC supported the proposed condition that it appoint three members to the appeals committee. It also largely supported the College's proposal for implementing this condition. It did, however, consider that it should be able to appoint alternative persons to those nominated by the College.[402]

13.378 The Commission imposes the following condition.

> **C15: Within one month of the authorisation commencing, the College shall write to the AHMC inviting it to nominate persons to sit on its appeals committee. At this time, it shall also nominate persons for consideration by the AHMC, which the AHMC may accept or reject.**
>
> **If the AHMC nominates persons, the composition of the Appeal Committee shall be altered to comprise:**
>
> - **a majority of members nominated by the Australian Health Ministers Conference (or a delegate); and**
>
> - **a minority of members who are College Fellows from sub-specialties other than the one from which the appeal originated.**
>
> **The College shall not accept as an appointed person to sit on its appeals committee, any person nominated by the AHMC who sits on any panel established in accordance with condition C6.**

13.379 The administrative processes underlying this condition are addressed in condition C19.

Grounds for appeal

13.380 The current grounds for appeal from a College decision are:

- an error in law or in due process occurred in the formulation of the original decision;

- relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision; and/or

- the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

13.381 The draft determination proposed adding the following grounds of appeal:

- that irrelevant information was considered in the making of the original decision;

- that procedures that were required by College policies to be observed in connection with the making of the decision were not observed;

- that the original decision was made for a purpose other than a purpose for which the power was conferred; and

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[402] AHMC submission, 25 June 2003, pp 16-17.

- that the original decision was made in accordance with a rule or policy without regard to the merits of the particular case.

13.382 In response, the College submitted that the proposed grounds are 'inapplicable or superfluous'.[403] In particular, it considered that;

- the first proposed additional ground is, by implication, incorporated into the College's second existing ground above;
- the second and fourth proposed additional grounds would be covered by the College's first existing ground; and
- the third proposed additional ground is inapplicable to the College as a non-government organisation.[404]

13.383 The AHMC supported the proposed condition but added that:

> if the current grounds of appeal encompass the changes proposed, Health Ministers would be prepared to endorse the status quo.[405]

13.384 The Commission is not satisfied that taking into account irrelevant information would necessarily be covered by a ground of appeal relating to not taking into account relevant information. They are separate grounds of appeal under the Commonwealth *Administrative Decisions (Judicial Review) Act 1977* (the ADJR Act).[406]

13.385 Similarly, the proposed grounds of appeal relating to non-observance of College procedures and to decisions made in accordance with a rule or policy without regard to the merits are separate grounds of appeal in the ADJR Act to the ground of appeal relating to an error of law.[407]

13.386 The Commission concedes that an appeal ground referring to a decision being made for a purpose 'other than a purpose for which the power was conferred' would not easily apply to the College. However, it considers that a more generally-expressed appeal ground is possible – that is, that a decision is made for an improper purpose. An improper purpose could include an anti-competitive purpose.

13.387 Overall, subject to the just-mentioned change, the Commission is satisfied that the additional grounds of appeal proposed in the draft determination are warranted.

C16: Within three months of authorisation commencing, the College shall amend its grounds for appeal so that they are as follows:

- **that an error in law or in due process occurred in the formulation of the original decision;**

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[403]College submission, 3 June 2003, p21.
[404]Ibid.
[405]AHMC submission, 25 June 2003, p17.
[406]Section 5(2), *ADJR Act 1977* (Cth).
[407]Section 1(b) of the ADJR Act relates to decision where procedures required by law to be observed were not observed; section 2(f) relates to an exercise of a discretionary power in accordance with a rule or policy without regard to the merits of the particular case; and section 1(f) relates to decisions involving an error of law.

- **that relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision;**

- **that irrelevant information was considered in the making of the original decision;**

- **that procedures that were required by College policies to be observed in connection with the making of the decision were not observed;**

- **that the original decision was made for an improper purpose;**

- **that the original decision was made in accordance with a rule or policy without regard to the merits of the particular case; and**

- **that the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.**

Procedural fairness

13.388 Generally, the College's appeals process would only help ensure that College decisions are ultimately correct if its operational rules provide appellants with a fair and reasonable opportunity to challenge the original decision – that is, if it provides them with procedural fairness.

13.389 The Commission's draft determination proposed several conditions to improve the apparent level of procedural fairness in its appeals process. In particular, these included:

- allowing appellants to be represented by lawyers; and

- allowing costs to be awarded against appellants only if they lose. This proposal was based on rule 18 of the College's appeal procedures which provides, among other things, that:

  > In the absence of a decision of the Council to the contrary, an applicant shall also be liable for the costs associated with the convening of the Appeals Committee (including travel, accommodation, honoraria, recording costs, etcetera). The Appeals Committee may recommend to the Council that some or all of the costs be waived.[409]

13.390 In response, the College submitted that it already complies with nearly all of the proposed conditions.[410] It also stated that:

> The College currently allows a legal representative to be present but not to prosecute the case... In discussions between the Jurisdictions and the College agreement has been reached that legal representation should continue to be treated as it is now. It has also been agreed that the Chairman of the Appeals Committee should be given the discretion to allow an appellant to be represented by a friend, if the chairman is of the view that the appellant would not be in a position to argue the case effectively without assistance.

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[409]College submission, 14 May 2001, Attachment 6
[410]College submission, 3 June 2003, pp22-23.

> There is no provision for awarding costs against an appellant at present, so this would constitute a reduction of rights for the appellant. The College proposes that the Commission consider removing this part of the Condition from the Final Determination.

13.391 The AHMC largely supported the condition subject to it being amended to 'include any beneficial aspects of the College's process'.[411] However, the AHMC did not support allowing appellants to engage legal representatives, as long as the Appeal Committee was able to:

> permit representation by a personal advocate, colleague or mentor in those cases where the Committee considers that an appellant could not, or would be disadvantaged in his or her appeal if required to, present in person.[412]

13.392 The AHMC also proposed:

- that College documentation of its Appeals Committee processes be revised to reflect the actual approach of refunding the application fee to successful appellants and not imposing actual hearings costs on any applicants;
- the removal of the clause referring to hearing costs;
- the inclusion of an additional procedural rule giving the Secretary of the Appeals Committee the power to waive the application fee in appropriate circumstances and giving the Chair of the Appeals Committee the power to review decisions of the Secretary on application of the appellant; and
- allowing sponsoring hospitals to appeal on behalf of overseas-trained doctors in relation to assessment decisions.[413]

13.393 The Commission generally recognises the merit in the responses above (but notes the apparent uncertainty about whether costs can be awarded against appellants). Consequently, it imposes the following condition:

C17: The College shall retain an appeals process and, within three months of authorisation commencing, amend the relevant rules to:

- **remove any rule providing for the awarding of costs against an appellant;**
- **require that successful appellants have their application fee refunded;**
- **provide the Secretary of the Appeals Committee with the power to waive the application fee in appropriate circumstances and giving the Chair of the Appeals Committee the power to review decisions of the Secretary on application of the appellant;**
- **require appellants to be provided with written reasons for an original decision within two weeks of requesting these reasons;**
- **require appeals hearings to be held within three months of the lodging of an appeal;**

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[411] AHMC submission, 25 June 2003, p18.
[412] Ibid
[413] Ibid, p17.

- **allow appellants to be represented by a personal advocate, colleague or mentor in those cases where the Appeals Committee considers that an appellant could not, or would be disadvantaged in his or her appeal if required to present in person; and**

- **allow sponsoring hospitals to appeal on behalf of overseas-trained doctors they are seeking to employ.**

The College shall continue to:

- **require appellants to lodge appeals in writing within three months of receiving reasons for a decision;**

- **notify appellants in writing of the date, time and location of an appeal hearing at least 14 days before it is held;**

- **require appellants to lodge written submissions to the appeals committee a reasonable period of time before an appeals hearing;**

- **require the appeals committee to issue a written decision within three weeks of the appeal hearing, along with reasons for this decision;**

- **allow appellants to present their case themselves at an appeals hearing; and**

- **allow appellants to have legal representatives present at the appeals hearing as observers (rather than participants).**

Information to remain publicly available until authorisation expires

C18: The information required to be made publicly available in conditions C4, C9, C11 and C13 shall remain publicly available until the relevant authorisation period expires.

Memoranda of understanding between the College and State and Commonwealth Governments

13.394 In response to the draft determination, the AHMC proposed to give effect to relevant conditions of authorisation through a national memorandum of understanding (MOU) with the AHMC, and individual MOU with each state and territory health minister as appropriate.[414] The AHMC therefore proposed a condition requiring the College to use its best efforts to reach these MOU. Since this proposal was first raised, health officials and the College have been developing the relevant MOU.

13.395 The Commission welcomes this initiative as it provides a useful mechanism for the practical implementation of several of the conditions proposed by the Commission. The relevant conditions are:

- condition C2 relating to the appointment of health minister nominees to teams assessing hospital posts;

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[414] AHMC submission, 25 June 2003, p18.

- condition C3 relating to the nomination by health minister of potentially accreditable training posts;

- condition C6 relating to the appointment of health minister nominees to teams assessing overseas-trained surgeons;

- condition C10 relating to the appointment of health minister nominees to teams selecting entrants into basic and advanced surgical training;

- condition C12 relating to consultation between health ministers and the College on basic surgical training posts; and

- condition C15 relating to the appointment of health minister nominees to the College's appeals committee.

13.396 MOUs between the College and health ministers (individually or nationally as appropriate) could set out the processes for achieving the outcomes required by these conditions.

13.397 The Commission therefore imposes the following condition:

C19: The College shall use its best efforts to:

- **establish memoranda of understanding with the Australian Health Ministers Conference or individual health ministers as practical and appropriate given the nature of the particular condition(s) being addressed in the memoranda; and**

- **ensure that these memoranda set out efficient and appropriate processes for implementing conditions C2, C3, C6, C10, C12, C15 and any other relevant condition of authorisation.**

The College and the AHMC or individual health ministers may agree to include any other matter in the relevant memoranda.

Consumer involvement in College processes

13.398 In response to the draft determination, the Australian Consumers' Association emphasised the need for consumer group representation on all relevant committees and boards.[416]

13.399 The Health Consumers' Council (Western Australia) submitted that:

> consumer groups are key stakeholders and should be considered for inclusion in assessment panels.[417]

13.400 While recognising the merit in principle of these suggestions, the Commission also notes the large number panels required to be established under the College's processes and consequently large number of meetings they have. For example, the College

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[416]Australian Consumers' Association submission, 10 March 2003, p2.
[417]Health Consumers' Council submission, 12 March 2003, p1.

considers around 60 assessments of overseas-trained practitioners annually.[418] Similarly, panels selecting entrants into basic and advanced surgical training are likely to meet around 50 times in total each year.[419] On the other hand, the College's appeals committee would meet far less frequently.

13.401 Overall, this raises practical issues about whether consumer groups could be involved in all relevant committees. Indeed, involvement by health minister nominees may raise resource issues even for the very substantially larger health departments.

13.402 The issue is then how to involve consumer groups in the College's processes in the most practical and effective way.

13.403 The Commission has required that consumer groups be consulted in the relevant reviews of the College's accreditation criteria and of the assessment of overseas-trained surgeons.

13.404 It also strongly considers that health ministers should consider nominating representatives of consumer groups to particular selection, assessment or appeals panels. These representatives would need to be appropriately trained and resourced by health departments.

13.405 In addition, the Commission considers that the AHMC should consider nominating a representative of a consumer group to the appeals committee, particularly given the appeal committee's role in suggesting improvements to College processes.

13.406 The Commission also considers that the College should develop a publicly-available consumer consultation policy to ensure appropriate consumer involvement in College policies and processes, in consultation with consumer groups. The Commission therefore imposes the following condition:

C20: Within three months of the authorisation commencing, the College shall write to consumer groups including the Australian Consumers' Association, the Consumers Federation of Australia, and the Consumers' Health Forum of Australia seeking their views on the appropriate involvement of consumer representatives in the College's processes. The College should also consult other relevant interested parties, including health ministers (or their delegates).

The College shall then prepare a draft policy on consumer involvement in its processes and seek the views of interested parties (including the aforementioned consumer groups) on this draft. The College shall then publicly issue a final policy. This policy must be publicly available within 6 months of the grant of authorisation. A copy must also be provided to the Commission at this time. The College may request an extension of time from the Commission, which the Commission may grant.

Generally, the policy should identify opportunities for consumer group involvement on relevant committees, panels etcetera, as well as identify when consumer groups need to be consulted on broader policy issues.

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[418] College submission, 3 June 2003, p10.
[419] Ibid, p14.

Implementation of conditions

13.407 In response to the draft determination, the AHMC submitted that:

> a progress report should be submitted to the Australian Health Ministers' Conference on implementing the recommended reforms after the first year, and with annual reporting to Health Ministers thereafter to monitor progress. The authorisation should be granted conditional on sufficient progress after two years.[420]

13.408 The College indicated that it had agreed to this.[421]

> **C21: Commencing in 2004, the College shall provide the Commission and health ministers with annual reports stating how it has implemented the conditions attached to this authorisation.**

Changes to the College's processes during the authorisation period

13.409 The Commission recognises that the College's surgical training program – like any educational programs – is in a constant state of evolution. Many, if not most, changes made to the program over time will not raise competition issues. For example, evolutionary changes made to the training curriculum in each surgical sub-specialty essentially raise educational rather than competition issues.

13.410 The Commission therefore proposes to extend authorisation to cover all amendments to the College's training and assessment processes over the term of the authorisation with the exception of the following:

- extending the length of basic surgical training or advanced surgical training in any specialty; and
- imposing requirements on trainees before they can graduate from basic or advanced surgical training in addition to existing examinations, training post rotations, skills courses and so on as set out in Chapter 6.

13.411 The College must also obviously comply with the conditions of authorisation imposed in this determination, which effectively prevents it from altering several key aspects of its training and assessment processes without Commission approval (for example, through an application for minor variation pursuant to section 91A of the Act or an application for revocation and substitution process pursuant to section 91B of the Act).

Conclusion

13.412 As indicated at paragraphs 13.274 to 13.277, the Commission will generally impose conditions where there may be some uncertainty about whether the public benefit outweighs the public detriment. This is what the Commission has done in relation to the College's application. It is confident that, subject to the proposed conditions, the College's training and assessment processes would generate a public benefit outweighing any public detriment.

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[420] AHMC submission, 22 June 2003, p20.
[421] College submission, 3 June 2003, p24.

Term of authorisation

13.413 In its draft determination, the Commission proposed to grant authorisation to the College's processes for:

- selecting basic and advanced surgical trainees;
- training basic and advanced surgical trainees; and
- examining basic and advanced surgical trainees

for six years, subject to conditions.

13.414 This term was intended to allow the Commission to re-assess these processes in the light of the AMC's follow up assessment of the College for AMC accreditation, which is due to occur in 2007. As previously discussed (at paragraph 1.24) the College was granted AMC accreditation (initially until 31 July 2008), extendable to ten years, if certain requirements are met by the College.

13.415 The Commission also proposed to grant authorisation subject to conditions to the College's processes for:

- assessing overseas-trained surgeons;
- accrediting hospitals for basic surgical training; and
- accrediting hospital posts for advanced surgical training

for four years.

13.416 The Commission noted that these processes had attracted considerable criticism from interested parties. It considered that this warranted an earlier review by the Commission of whether the public benefit generated by these processes continues to outweigh any public detriment.

13.417 In its response to the draft determination, the AHMC supported these periods of authorisation.

13.418 However, the College proposed that:

> the Commission not impose a time limit on its authorisation on the grounds that the AMC accreditation process would ensure that the College's processes would be subject to on-going independent scrutiny...
>
> the process has also cost the College dearly in both time and money and it should not be faced with regular re-visiting of its authorisation status through a costly and time-consuming process when the checks and balances are already inherent in the terms of the authorisation and can be adhered to through less costly or complex reporting.
>
> The College also maintains that the concept of a two-tiered system makes a difficult situation even worse, because, with the AMC and the Commission's requirements, the College will be placed in a position of constant applications for authorisation or accreditation in addition to annual reporting to both bodies on progress between applications. This level of oversight is both onerous and unnecessary.

> This is particularly so given that the Commission has the power to revoke the authorisation if the College fails to comply with the Conditions.[422]

13.419 As regards the proposed six year time period, the College submitted that:

> Commission appears to have tied the time-limit to the AMC Review occurring in 2007, which involves only a detailed report from the College on its activities rather than a full application for accreditation.
>
> If the Commission wishes to reassess these processes in light of the AMC Review, the College submits that the final determination specifically provide that the period of authorisation should be extended by a further four years if the AMC decides that the interim report in 2007 meets its requirements for the accreditation to be confirmed for the full ten-year term ending in 2012.

13.420 As regards the proposed four year term, the College submitted that it:

> four years would be an insufficient period of time to give the Commission a clear view of whether the Conditions have affected the nature of the public benefit generated by [its] processes...
>
> the College would need to begin making its application in the third year to assure itself of the necessary continuity. So there will have been barely two years of operation of the new processes before they are reviewed. The College questions whether the Commission will be able to engage in any meaningful assessment of the impact of the Conditions on public benefit over such a short period.

13.421 In light of these concerns, the College proposed:

> that the term of authorisation be linked to the on-going AMC accreditation process, so that the authorisation will expire in 2013 unless the AMC mid-term Review in 2007 determines that the College must submit a full accreditation submission.

13.422 The Australian Consumers Association submitted that the proposed authorisation periods were too long.[423]

Commission view

13.423 Generally, the Commission has concluded that the College's training program potentially generate significant public benefit and significant public detriment. It was open to the Commission to deny authorisation in such a situation. While it has identified conditions which it considers are likely to ensure that the College's processes generate a net public benefit, the fact that the Commission needed to impose conditions to allow authorisation to be granted, by itself, dictates against a lengthy period of authorisation.

13.424 Moreover, the College's processes that the draft determination proposed be granted authorisation for four years are those elements with the greatest potential impact on competition. If concerns emerge that the conditions imposed on these processes are insufficient and that more far-reaching conditions are desirable, a four year authorisation period will ensure that the situation can be reviewed in a formal authorisation process within a reasonable period. The Commission also notes that a four year period will provide health ministers, consumer groups and other interested parties with at least two years of experience on which to draw reliable conclusions about the conditions of authorisation, which the Commission considers should be sufficient.

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[422] Ibid pp24-25.
[423] Australian Consumers' Association submission, 10 March 2003, p2

13.425 As indicated above (and as the College notes), the six year period proposed in the draft determination was intended to allow the Commission to review the College's selection, training and assessment of surgical trainees in light of the Australian Medical Council's decision in 2007 on whether to extend accreditation by four years. It seems reasonable to anticipate that the report to be provided by the College to the AMC and the AMC's response to this report – along with the annual reports to be provide to the Commission and health ministers – would provide the foundation for the College's re-application for authorisation.

13.426 In light of the above, the Commission considers that the authorisations periods proposed in the draft determination are appropriate.

13.427 Having said this, if the annual progress reports are not satisfactory, and if the concerns about the College raised by interested parties in the current authorisation process have not subsided, along with the Commission's broader concerns about the College, then it is likely that, in considering applications for reauthorisation from the College's processes (whether after four or six years), the Commission is likely to be reconsidering whether granting subject to conditions was an appropriate approach, or at least questioning whether the conditions imposed in this determination had proved sufficient.

13.428 It should also be added that the Commission is now familiar with College processes and the issues they raise. Moreover, health ministers and departments will now be closely involved with the College. They should be readily able to provide views on a re-authorisation application. In addition, the extended consultation process allowed for the College's current application was a product of the fact that this was the College's initial application for authorisation. This will not be a factor for any application for re-authorisations. The Commission also notes that the Commonwealth Government has accepted the Dawson review recommendation that the Commission be required to assess authorisation applications within six months (although the Act must be amended to implement this recommendation).

14. RELATED ISSUES

14.1 In the course of the Commission's assessment of the College's application for authorisation, numerous other issues have arisen which impact on the quality, availability and affordability of surgical care. The primary issues are discussed below.

Shortage of surgeons

14.2 The need for the conditions imposed on the College's authorisation is heightened considerably by the prospect that surgical trainee numbers may need to be increased, possibly significantly, in the coming years for reasons including the following:

- the ageing of the Australian population, which is likely to generally increase health care demands;
- the ageing of the Australian surgical profession;
- the possibility that many surgeons are considering retiring early. The Commission understands that the College recently published a survey indicating that a substantial number of surgeons were considering doing this;
- the possibility that the demand for Australian surgeons to work overseas will increase;
- the apparent reluctance of younger surgeons, and particularly female surgeons, to work the long hours many surgeons have traditionally worked; and
- the implementation of the Australian Medical Association's safe working hours policy.

14.3 The Commission has also raised several concerns about whether the AMWAC methodology for determining the required number of specialist training places is appropriate (see paragraphs 7.50-7.54). It has now gone a step further and requested Professor Jeff Borland of the University of Melbourne to re-examine whether the current supply of surgeons is sufficient. Professor Borland concluded that:

- there is a strong likelihood of a current shortage in supply in urology and otolaryngology – head and neck surgery;
- there is likely to be a shortage of supply in general and vascular surgery and orthopaedics; and
- the supply of surgeons is likely to be adequate in neurosurgery and cardio-thoracic surgery.

14.4 Future increases in surgical training number targets would be needed to remedy the shortages in the relevant sub-specialties.

14.5 A copy of Professor Borland's paper is at Attachment C to this determination.

14.6 A recent report commissioned by the College confirms the Commission's view that a

shortage of surgeons exists in Australia.[424]

Hunter Area Health Service/University of Newcastle proposal for medical specialist training program

14.7 Hunter Health's proposal for a new training program is outlined at paragraphs 13.17-20.

14.8 The Commission considers it potentially represents a major turning point in the history of medical specialist training in Australia.

14.9 The Commission will be liaising closely with Hunter Health and the University of Newcastle as they seek to establish their new training program, as well as actively monitoring the situation generally.

14.10 The Commission will vigorously investigate all complaints that the development or ongoing operation of the new training program is being impeded by anti-competitive activity.

14.11 The Commission emphasises that the immunity from legal action under the Act provided by this authorisation does not extend to conduct beyond the College's training and assessment processes.

The Australian Medical Council

14.12 Hunter Health's training program, if it does not involve the College, will need to be accredited by the Australian Medical Council (AMC) to ensure it is of an appropriate standard. The AMC is an independent national standards body established by the Commonwealth and state health ministers to, among other things, accredit all providers of specialist medical education and training.[425]

14.13 The Commission understands that the AMC has a forward work program for accrediting the existing medical colleges.[426]

14.14 If it becomes clear that an application will need to be made to the AMC by the Hunter Area Health Service and the University of Newcastle, the Commission urges the AMC to revise this work plan so as to make room to assess this proposal at the earliest opportunity. If necessary, health ministers should also consider whether additional temporary funding for the AMC is required to allow it to undertake this task.

14.15 The Commission also notes that the AMC will need to consider how it ensures that a fair assessment is made, given that its assessment teams typically include members of specialist colleges – that is, Hunter's prospective competitors.[427]

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[424] *The outlook for surgical services in Australia*, Bob Birrell, Lesleyanne Hawthorne and Virginia Rapson, Centre for Population and Urban Research, Monash University, June 2003.

[425] See www.amc.org.au/review.asp.

[426] See www.amc.org.au/forwardp.asp.

[427] For example, the assessment team which assessed the Royal Australasian College of Surgeons included one RACS member, four specialists who were members of other specialist medical colleges, one medical administrator, medical academic, registrar and overseas surgeon and the executive director of another specialist college.

Private hospitals and surgical training

14.16 In its response to the draft determination, the Australian Private Hospitals Association (APHA) submitted that the private hospital sector could participate in the training of surgeons. In particular, APHA suggested that the College be required to:

- invite private hospitals to nominate a representative to participate in the assessment of hospitals (for basic surgical training) and hospital training posts (for advanced surgical training);
- invite the APHA to nominate any private hospital for basic surgical training and/or hospital training posts for advanced surgical training for which they wish to seek accreditation; and
- consult private hospitals, through the APHA, before finalising the limit on the number and distribution of basic training posts for a particular year. [428]

14.17 The AHMC:

- is not opposed to the involvement of private hospitals in surgical training;
- however, it considers there are issues which would require careful consideration, including funding;
- there is already an AHMAC Working Party established to research issues relevant to medical specialist training outside teaching hospitals; and
- that these issues should be the subject of discussions between the College, APHA and government representatives, including representatives of the AHMAC working party.[429]

14.18 The AHMC submitted that if the proposal to involve private hospitals in surgical training proceeds, it favours a coordinated approach to hospitals (including private hospitals) advising the College of hospitals and posts requiring accreditation through health ministers, rather than the establishment of separate processes for the private sector. The AHMC submitted that it considers a coordinated network of training to be essential.[430]

14.19 The College recognised that any comprehensive approach to surgical training must take into account the role that is being played or can be played by the Catholic and private hospitals. The College highlighted that it has already commenced discussions with the APHA and Catholic Health Australia and the jurisdictions in an attempt to coordinate their involvement in the identification and accreditation of hospitals and training posts.[431]

Commission view

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[428] Australian Private Hospitals Association submission to the Commission, 14 March 2003, p3.
[429] Australian Health Ministers Conference submission to the Commission (insert date), p2.
[430] Ibid.
[431] College submission, 3 June 2003, p2.

14.20 The growing size of the private hospital sector in Australia seems likely to provide an opportunity for expanding the range of facilities that host surgical training. Private hospitals would therefore seem, in principle, to have an important role to play in ensuring that the size of the surgical profession (and other medical specialties) is sufficient to meet patient demands into the future. The Commission also understands that private hospitals offer training in procedures that might not necessarily be available in all public teaching hospitals.

14.21 The Commission accepts that there are practical issues to be worked through, and is encouraged by the fact that health ministers and the College have both indicated that they are moving to resolve these issues.

Greater diversity of representation on College Committees

14.22 The AHMC's response to the draft determination proposed that authorisation be subject to a condition that all panels and committees established by the College should include male and female representation as far as possible.[432] The College indicated that it would be able to comply with this proposed condition.[433]

14.23 Generally, the Commission recognises that organisations will often benefit from participation in their processes by a broad range of interests.

14.24 However, as a competition regulator, the Commission considers it appropriate for its analysis of authorisation applications to focus primarily on competition and economic efficiency matters. On this basis, it concludes that the benefits in question are not relevant to its analysis of the College's application. Consequently, it is unable to impose the proposed condition.

Other potential reforms

14.25 In its draft determination, the Commission sought the views of interested parties on further options it considered might be necessary to ensure that the College's training and assessment processes generate a net public benefit.

Accreditation of hospitals for advanced surgical training rather than hospital posts

14.26 Prior to the draft determination, NSW Health submitted that:

> The College's submission does not explain why it considers that it is preferable to accredit individual hospital posts rather than accrediting hospitals. If the College were to move to a system where it accredited sites (hospitals) rather than posts, there would be more accredited positions available in specialties like orthopaedic surgery where there are currently large numbers of 'unaccredited' positions.[434]

14.27 In response, the College explained that it was considering the proposition to accredit hospitals, rather than individual posts in hospitals. However, the College considers that whether this will create additional accredited positions is debatable. However, the College highlighted other advantages of this proposal, including cost, time and better articulation of training opportunities.[435] On the other hand, it also highlighted

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[432]AHMC submission, 25 June 2003, p18.
[433]College submission, 3 June 2003, p23.
[434]NSW Health submission, April 2002, paragraph 5.1.17.
[435]College submission, 13 March 2003, p 20.

that it would need to be assured that every advanced surgical trainee would receive exposure to operative procedures which at least meets an agreed minimum.[436]

14.28 The AHMC expressed an interest in working with the College to explore the feasibility of accreditation of hospitals rather than hospital posts for advanced surgical training. They considered the issue appropriate for inclusion in the terms of reference for the review of the College's accreditation criteria.[437] The Commission supports this proposal (see paragraph 13.290).

Selection of surgical trainees

14.29 The draft determination questioned whether the College should continue to control the selection of surgical trainees. No interested party responded to this issue.

Establishing a subsidiary/new company to administer training and assessment processes

14.30 The draft determination questioned whether the proposal for health department representatives to be included on teams assessing, for example, surgical training posts could be extended to include health department representatives on, for example, the specialty boards of training for each surgical sub-specialty within the College or even the Education Policy Board. More radically, the draft determination suggested that the College could be required to establish a subsidiary company to administer its training and assessment processes, a minority of whose board could be health department nominees.

14.31 In response, the College opposed the suggestion that a subsidiary company be established. It contended that the proposal would serve no useful purpose and would add considerably to the cost of surgical training and selection.[438]

14.32 The AHMC indicated that it is interested in the most effective way for training to be provided by the College, but did not have a position about the establishment by the College of a subsidiary company to deliver training functions. The AHMC stated that any proposal forthcoming would be considered on its merits.[439]

14.33 The Australian Consumers' Association strongly supported the suggestion.[440]

14.34 Particularly in light of the view of the AHMC, the Commission has not imposed a condition requiring, for example, that the College establish a subsidiary to administer its training program. However, such a suggestion may need to be seriously reconsidered if the concerns of interested parties about the College have not subsided by the time that authorisation expires.

The Australian Medical Workforce Advisory Committee (AMWAC)

AMWAC methodology

14.35 In its draft determination the Commission suggested that the methodology used by AMWAC to determine surgical training number targets needs to be improved to

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[436]Ibid.
[437]AHMC submission, 25 June 2003, p7.
[438]College submission, 13 March 2003, p20.
[439]AHMC submission, 22 June 2003, p2.
[440]ACA submission, 10 March 2003, p2.

ensure that AMWAC does not underestimate (or overestimate) the required number. The recent review of AMWAC, while noting that its methodology had improved, recommended that AMWAC make improvements to the technical methodology used (see paragraph 7.55).

14.36 In response, the AHMC submitted that:

> As a result of the 2002 AMWAC Review, the AMWAC methodology has been refined to take into account comments such as those made by the Commission. In some cases this will simply involve making aspects of the methodology more explicit.
>
> Jurisdictions consider AMWAC's methodology to be appropriate and effective in the context of government policy decision making.[441]

14.37 In particular, the draft determination expressed concerns that for AMWAC simply to work on the basis that projections should be aimed at ensuring the ratio of surgeons to population is kept stable rather than assessing whether that ratio is appropriate in the first place would be to avoid dealing with the most fundamental issue a workforce advisory committee would address.[442]

14.38 In response, the AHMC submitted that:

> AMWAC projections are based on an assessment of the expected change in service requirements and supply for the workforce under review, and all AMWAC workforce recommendations are framed in this context.
>
> Adherence to a predetermined surgeon to population ratio is not the basis for the framing of the training intake recommendations.[443]

14.39 The draft determination also stated that, as a matter of priority, AMWAC should undertake a review of current adequacy of supply of surgeons.[444]

14.40 In response, the AHMC submitted that

> Updates of AMWAC speciality reports planned for 2003-04 are Orthopaedic Surgery, ENT surgery and Neurosurgery.[445]

14.41 While the Commission's concerns about some of the earlier reviews of surgical specialties remain, it welcomes the fact that the AMWAC methodology has been improved and that the Commission's views to the 2002 review of AMWAC have been taken into account. It further welcomes the fact that AMWAC will be re-examining key surgical sub-specialties as part of its 2003-04 work program.[446]

Implementation of AMWAC targets

14.42 In its draft determination, the Commission raised concerns about the implementation of AMWAC targets. In particular, the draft stated that:

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[441] AHMC submission, 25 June 2003, p4.
[442] Executive Summary of draft determination, 6 February 2003, p viii.
[443] AHMC submission, 25 June 2003, p4.
[444] Ibid.
[445] Ibid.
[446] Ibid.

the process for implementing AMWAC targets needs reform. In particular, the Commission considers that, where such a process does not already exist, there is a need for systematic process within state and territory health departments to implement AMWAC targets. As part of this, health departments would need to ensure that the necessary funding was available, not just for salaries and on-costs, but for any infrastructure requirements. If AMWAC targets are not to be systematically implemented, then questions arise about the value of having AMWAC in the first place.[447]

14.43 In response, the AHMC submitted that the implementation of AMWAC targets (subsequently approved by AHMAC and the AHMC) for the number of specialist medical training posts:

is the responsibility of state/territory health departments, who work with the relevant professional college to ensure that the adjustments are made. This implementation process is overseen by AHWOC.[448]

14.44 Further, the AHMC submitted that a monitoring process that will apply to AMWAC recommendations:

The process will involve each jurisdiction nominating a contact person to coordinate information on implementation of AMWAC recommendations and to liaise with the National Health Workforce Secretariat. Jurisdictions will be required to submit an annual return to the National Health Workforce Secretariat outlining their implementation of AMWAC recommendations over the past year. AMWAC will use this information to produce a report on implementation progress to be presented to AHMAC and AHMC each year on a set date. The report will accompany AMWAC's Annual Report to AHMAC.

In addition, the Commonwealth on behalf of AHWOC is continuing to work with jurisdictions regarding issues associated with the implementation process.

However, it must be noted that the approach of the local specialist Colleges can have an impact in relation to implementing AMWAC recommendations. Difficulties can also arise where there is little interest in training in the particular specialty.[449]

14.45 The Commission welcomes the AHMC's submission affirming that state and territory health departments have an obligation to implement AMWAC recommendations and that each state and territory will now submit an annual report on its implementation of AMWAC recommendations. However, the Commission reiterates its belief that it seems difficult for government to meet AMWAC targets for their state or territory without some form of state or territory-wide co-ordination of the process.

14.46 For example, where AMWAC recommends an increase in the number of training posts in a surgical sub-specialty in a state or territory, it would appear that the relevant state or territory health department would need a process that could:

- identify the required number of potentially accreditable training posts. It is recognised that, in doing this, health departments would seem likely to need to involve individual hospitals and possibly the College. The health department's service-provision needs would also be highly relevant as regards the location of potential training posts. Importantly, any additional funding requirements would need to be identified; and

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[447] Draft determination, 6 February 2003, para 13.40.
[448] AHMC submission, 25 June 2003, Attachment 1, p33. AHWOC refers to the Australian Health Workforce Officials Committee, a sub-committee of AHMAC.
[449] AHMC submission, 22 June 2003, p5.

- initiate an application for accreditation to the College and undertaking whatever feasibly needs to be done to ensure accreditation is obtained (or ensuring that these tasks are undertaken).

14.47 On the information set out in paragraphs 8.15-8.25, it appears to the Commission that, other than perhaps in Queensland and possibly in Victoria, state and territory governments have not established systematic processes to ensure that the target number of accredited medical training posts is achieved.

Assessing overseas-trained surgeons

The 'equivalence' test

14.48 Currently, specialist medical colleges, including the Royal Australasian College of Surgeons, assess whether overseas-trained specialists are equivalent to Australian-trained surgeons.

14.49 The College's current practice is to examine the training, qualifications and experience of overseas-trained surgeons when applying this test. However, this may not have always been the case. For example, it appears that, in 1994, when the College first assessed the overseas-trained cardio-thoracic surgeon referred to at paragraph 13.117, it only took account of his qualifications and ignored his experience.

14.50 The Commission also notes that the then Commonwealth Minister for Health and Aged Care, the Hon Dr Michael Wooldridge MP, at the Area of Need Forum convened by the Committee of Presidents of Medical Colleges and the Australian Medical Council on 1 December 2000, suggested that the assessment of overseas-trained practitioners might be less problematic if decisions were made on the basis of competency rather than equivalence of training and qualifications. He further acknowledged that this would constitute a significant and challenging change in focus for specialist medical colleges, but considered that it would enable individual doctors to be judged on their merits and would therefore minimise accusations of discrimination.[450]

14.51 The Commission considers that, at the least, the qualifications and experience of overseas-trained specialists should be taken into account (as the College now does). It further considers that the test used by the specialist medical colleges needs to be changed so as to more accurately reflect this view.

14.52 In its draft determination the Commission suggested that overseas-trained surgeons be required to be 'competent' before being able to practise in Australia. However, it understands that such a test might raise issues about the possible legal liability of medical colleges if, for example, the overseas-trained surgeon was subsequently sued for medical negligence.

14.53 The AHMC, in response to the draft determination, submitted that the terms of reference for the review of how the College assesses overseas trained surgeons (condition 5 of the draft determination) should be widened to include consideration of

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[450]Proceedings of an Area of Need Forum convened by the Committee of Presidents of Medical Colleges and the Australian Medical Council, 1 December2000, p3.

whether equivalence, substantial comparability or some other test is the preferred test for assessing overseas trained surgeons.[451]

14.54 The Commission supports this approach and has widened the relevant condition in this final determination (see paragraph 13.311).

Attracting overseas-trained doctors

14.55 Hospitals in rural and regional areas often attempt to recruiting overseas-trained specialists to address the significant workforce shortages they face.[452]

14.56 However, the Commission is aware of anecdotal evidence that this is often a difficult process in practice. The hospitals and/or the doctors they are seeking to recruit need to negotiate their way through several different, but interconnecting, processes before being able to work in Australia.

14.57 In particular, overseas-trained doctors or hospitals may need to obtain: visas through the Commonwealth Department of Immigration, Multicultural and Indigenous Affairs; area of need exemptions from state and territory governments; area-of-need exemptions from Commonwealth rules prohibiting the granting of Medicare Provider numbers to overseas-trained doctors; assessments from the relevant medical specialist college; and registration from a state or territory medical registration board.

14.58 It appears that a lack of co-ordination between these processes may often be leading to significant delays in the arrival of often sorely-needed overseas-trained specialists or even deterring some from working in Australia at all.

14.59 In addition, the Commission has also been informed anecdotally that, for example, area of need exemptions may only initially be granted by state health departments for short periods (for example, 2 years), although it is possible to obtain extensions once the initial period has expired. The problem is that this creates uncertainty for overseas-trained specialist as regards how long they might be employed at a particular hospital, which reduces the attractiveness of the post.

14.60 The Commission considers that the AHMC or individual health departments as appropriate should urgently examine the extent to which the problems raised above are occurring. If significant problems are found to exist, urgent measures need to be taken to remedy them so that appropriately-qualified overseas-trained doctors can be recruited to areas of need without unnecessary delay.

Other medical specialist colleges

14.61 The Commission is considering its approach to the remaining medical specialist colleges. It will be seeking consultations with these colleges soon. It is conscious of resource issues for all involved.

Impact of the proposed reforms on the College

14.62 Given the grant of authorisation, albeit subject to conditions, the College will continue to play a pivotal role in training surgeons in Australia. Its influence also extends well beyond this. In particular:

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[451] AHMC submission, 25 June 2003, p10.
[452] For example, see Hunter Area Health Service submission, 30 May 2003.

- College Fellows have significant input into AMWAC processes. For example, several College Fellows typically participate in working parties determining training number targets for particular surgical sub-specialties;

- College Fellows are likely to often have considerable influence over when accreditation is sought for an advanced training post (see paragraph 13.163); and

- College Fellows sit on the 'credentialing' committees which determine whether surgeons (trained in Australia or overseas) should be granted access to private hospitals to undertake surgical procedures. They also sit on committees selecting surgeons to take up public hospital positions.

14.63 That the College dominates all things relevant to the surgical profession in Australia is to be expected given that ninety per cent of surgeons in Australia are College Fellows.

14.64 This will inevitably continue unless and until competing professional organisations for surgeons arise.

14.65 The conditions proposed by the Commission – and particularly the involvement of state and territory governments in College processes – are essentially intended to place checks and balances on the College, to ensure that its dominance of surgical training and assessment processes serve the public interest.

Recognition of medical specialist graduates who do not maintain college membership

14.66 Graduates of the College's surgical training program are granted Fellowship of the College and permitted to use the designation 'FRACS'.[453] The use of this designation is the only formal way that surgeons can inform the public that they have completed the College's training program. However, graduates of the College's advanced surgical training program are only able to use the FRACS designation so long as they remain Fellows of the College.

14.67 It is acknowledged that the existence of the 'FRACS' designation as the only way for surgeons to indicate that they have completed the College's training program is a product of historical circumstances. However, it does mean that graduates of the College's advanced surgical training program who, for whatever reason, are not College Fellows have no formal and recognised way of indicating to the public that they are graduates. This may have a significant effect on their capacity to compete for patients, particularly in the private market.

14.68 While the Commission recognises that College membership provides benefits (for example, through continuing medical education for surgeons), it nevertheless considers that there are also potential benefits in graduates from medical specialist training being able to indicate to the public, separate from being a member of a college, that they have successfully completed medical specialist training. For example, the College might award something along the lines of a 'Diploma of Surgery (RACS)'.

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[453]The College retains the discretion to withhold granting Fellowship but submits it has never exercised this discretion.

14.69 However, the Commission understands that the awarding of higher education qualifications is regulated through the Australian Qualifications Framework established by Commonwealth, state and territory education and training ministers. Commonwealth, state and territory legislation also protects the word 'degree'. Consequently, the Commission, at this stage, only encourages medical specialist colleges to examine the possibilities in this area.

[457] Draft determination, 6 February 2003, para 13.14.

15. CONCLUDING REMARKS

15.1 The Commission has assessed the public benefit and detriment generated by the College's application in the context of the general restrictions on the supply of surgeons imposed via government workforce planning arrangements – for example, the AMWAC process. In particular, it has sought to distinguish the public benefit and detriment generated specifically by the College's processes from any benefit and detriment generated by government workforce planning arrangements.

15.2 Importantly, the existence of government workforce arrangements does not remove the potential for the College to restrict entry to the surgical profession. Given that the purpose of these arrangements is to balance supply and demand, there is still the potential for the College, through its standard-setting role, to further restrict entry into the profession – that is, to create an undersupply. Broadly, the conditions proposed to be placed on the authorisation granted to the College are precautionary conditions that aim to minimise this possibility, particularly as the grant of authorisation renders the College immune from legal action under the Act.

15.3 The need for these conditions is highlighted by the fact – now recognised by the College – that there is a shortage of surgeons in Australia (see paragraphs 14.2 to 14.6).

15.4 Ultimately, the aim is to have a surgical training and assessment system which is highly responsive to quality concerns via the role of the College, while also being responsive to concerns about access and affordability via input particularly from governments, which are the largest employers of surgeons in Australia.

15.5 The Commission emphasised in its draft determination that the conditions it was proposing on the College's authorisation were unlikely to achieve their intended outcomes unless governments commit to making them work.[457] The Commission therefore welcomes the submission of the AHMC that:

> health ministers are prepared to commit to, and meet the costs of, that involvement [in College processes] either individually, in the case of local participation, and on a national cost-shared basis, in the case of national participation.[458]

15.6 The Commission also notes that, if governments choose not to participate in the College's training and assessment processes as envisaged in this determination, the College's authorisation and the resultant immunity from legal action under the Act will not be affected.

15.7 Finally, there is long-running debate as to whether the failure to meet AMWAC targets for surgical training posts is the fault of the College or the fault of governments, by failing to provide sufficient funding. Each party has tended to blame the other. As indicated above, the reforms imposed on the College are intended to minimise the potential for it to restrict surgical training numbers. If, as intended,

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[457] Draft determination, 6 February 2003, para 13.14.
[458] AHMC submission, 22 June 2003, p1.

these reforms result in concerns about the College subsiding, the focus would then be on government if concerns persist that surgical training numbers are insufficient.

16. Determination

16.1 On 28 November 2000, the Royal Australasian College of Surgeons (the College) lodged application A90765 with the Australian Competition and Consumer Commission (the Commission).

16.2 A full submission in support of the application for authorisation was lodged by the College with the Commission on 30 March 2001.

16.3 The application for authorisation A90765 is made on behalf of the College, its officers, employees, current Fellows, as well as the current members of specialist societies and associations affiliated with the College as listed at Attachment A.

16.4 Pursuant to section 88(10) of the *Trade Practices Act 1974* (the Act), the application is also lodged on behalf of all future College Fellows, as well as future members of the College's affiliated specialist societies and associations.

16.5 The College seeks authorisation for the arrangement between persons on whose behalf the application is made, pursuant to which the College administers processes for:

- selecting, training and examining basic surgical trainees;
- selecting, training and examining advanced surgical trainees in all nine surgical sub-specialties;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

16.6 The above training and assessment processes are detailed in Chapter 6 of this determination.

16.7 The application was made under subsection 88(1) of the Act and the Competition Codes for each state and territory for authorisation to give effect to a contract, arrangement or understanding, a provision of which has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

16.8 For the reasons outlined in Chapter 13 of this determination, and pursuant to section 90(7) of the Act, the Commission concludes that, subject to the conditions set out below, in all the circumstances, the arrangement for which authorisation is sought:

- is likely to result in a benefit to the public; and
- that benefit would outweigh the detriment to the public constituted by any lessening of competition that would be likely to result from the arrangement.

16.9 The Commission therefore grants authorisation to application A90765 under section 88 of the Act and the Competition Codes to the arrangement pursuant to which the College administers processes for (as detailed in Chapter 6):

- selecting, training and examining basic surgical trainees;
- selecting, training and examining advanced surgical trainees in all nine surgical sub-specialities;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

16.10 Authorisation is granted, subject to the College complying with the conditions of authorisation imposed by this determination, to cover all amendments to the College's training and assessment processes over the term of the authorisation with the exception of the following:

- extending the length of basic surgical training or advanced surgical training in any specialty;
- imposing requirements on trainees before they can graduate from basic or advanced surgical training in addition to existing examinations, rotations, skills courses and so on as set out in Chapter 6.

16.11 This determination is made on 30 June 2003. If no application for review is made to the Australian Competition Tribunal (the Tribunal) in accordance with section 101 of the Act, it will come into force on 22 July 2003.

16.12 If an application for review is made to the Tribunal, the determination will come into force:

- where an application is not withdrawn – on the day on which the Tribunal makes a determination on the review; or
- where the application is withdrawn – on the day on which the application is withdrawn.

16.13 The authorisation is subject to the following conditions:

Accreditation of hospitals for basic surgical training and hospital training posts for advanced surgical training

Accreditation criteria

C1: In accordance with the terms of reference at Attachment D, the College is required to establish a public independent review of the criteria for accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training and associated matters.

Accreditation teams

C2: Within one month of authorisation commencing, the College shall invite the health minister in each state or territory to nominate persons to participate in the assessment of hospitals (for basic surgical training) and hospital training posts (for advanced surgical training) in that minister's state or territory. The College shall

ensure that, if the health minister nominates members, each team established to assess a hospital or hospital posts in that state or territory includes a member nominated by the minister.

Ensuring all hospital posts are considered for accreditation

C3: Within one month of the accreditation criteria resulting from the review specified in Condition C1 being implemented, and at least annually thereafter, the College shall write to state and territory health ministers requesting that they nominate any hospitals for basic surgical training and/or hospital training posts for advanced surgical training for which they wish to seek accreditation.

General transparency

C4: The College shall:

- continue to advise the applicant – that is, health departments, area health services or individual hospitals, as the case may be – as to decisions on the accreditation of hospitals for basic surgical training and hospital training posts (or hospitals[459]) for advanced surgical training in writing within six months;

- continue to provide written reasons for decisions and advise applicants of their appeal rights;

- continue to complete re-assessments of hospitals for basic surgical training and hospital training posts (or hospitals) for advanced surgical training before their existing accreditation expires;

- annually publish:

  - the number of requests for accreditation of hospitals for basic surgical training and hospital training posts (or hospitals) for advanced surgical training by specialty and hospital;

  - the number of re-assessments of existing advanced surgical training posts (or hospitals) by specialty and hospital and the number of re-assessments of hospitals for basic surgical training;

  - the number of advanced surgical training posts (or hospitals) granted accreditation or re-accreditation and the number of advanced surgical training posts (or hospitals) not accredited or granted re-accreditation;

  - the number of hospitals granted accreditation for basic surgical training and the number of hospitals denied accreditation;

  - the basis on which accreditation was not granted specifying which standards the hospital or post did not meet;

[459] This recognises that the College may commence accrediting hospitals rather than hospital posts for advanced surgical training as a result of the review imposed by condition C1.

- the number of assessments completed in less than six months; and the number of assessments completed in more than six months;

- the number, if any, of reassessments not completed before the expiry of existing accreditation;

- the number of appeals lodged and the appeal results; and

- a description of the assessment process.

Assessment of overseas-trained surgeons

Assessment criteria

C5: In accordance with the terms of reference at Attachment E, the College shall establish an independent committee to publicly assess whether the test that specialist medical colleges use to asses overseas trained surgeons should be equivalence, substantial comparability, competence or some other test, including in relation to:

- the assessment of an overseas trained surgeon who is seeking full registration to practise as a specialist in Australia;

- the assessment of an overseas trained surgeon who is seeking conditional registration to practise within a limited area of specialisation or subspecialty practice; and

- the assessment of an overseas trained surgeon who is seeking registration to practise in an area of need, and whose practice is limited by conditional registration to a specific role that is determined by the job description for the position.

In accordance with Attachment E, the College shall prepare public guidelines on how it applies the test for assessing overseas-trained surgeons.

Assessment teams

C6: Within one month of authorisation commencing, the College shall invite the health minister in each state or territory (or delegate) to nominate persons to participate in the assessment of overseas-trained surgeons.

If nominations are made, the College shall ensure that each team formed to assess an overseas-trained surgeon includes a person nominated by the health minister (or delegate) for the state or territory which is the most relevant in the circumstances (for example, the state or territory where the overseas-trained surgeon resides or wishes to work).

Procedural fairness

C7: The College shall inform overseas-trained surgeons intending to work in an area of need of the outcome of its assessment within eight weeks and otherwise within three months. The eight-week and three-month periods shall commence when the College receives all information required from the overseas-trained surgeon concerned. The College shall provide written reasons to all overseas-trained surgeons

whom it assesses as not being equivalent to an Australian-trained surgeon and shall advise these surgeons of their appeal rights.

Overseas-trained surgeons who have already been assessed by the College

C8: If requested, the College shall re-assess any overseas-trained surgeon it assessed and found not to be equivalent to an Australian-trained surgeon or was in the process of assessing prior to the implementation of the interim guidelines required under condition C5.

General transparency

C9: The College shall annually publish:

- the number of applications received for assessments of overseas-trained surgeons other than in areas-of-need;
- the number of applications received for assessments of overseas-trained surgeons to work in areas-of-need;
- the number of assessments of overseas-trained surgeons seeking to work in areas-of-need completed;
- the number of assessments of overseas-trained surgeons other than those seeking to work in areas-of-need completed;
- the number of assessments of overseas-trained surgeons not seeking to work in areas-of-need completed in three months or less and the number of assessments completed in more than three months;
- the number of assessments of overseas-trained surgeons seeking to work in areas-of-need completed in eight weeks or less and the number of assessments completed in more than eight weeks;
- the number of assessments where overseas-trained surgeons were required to complete basic and advanced surgical training;
- the number of assessments where overseas-trained surgeons were required to complete advanced surgical training only;
- the number of assessments where overseas-trained surgeons were required to complete a period of supervised work;
- the number of overseas trained surgeons assessed for conditional registration on behalf of the AMC;
- the number of overseas trained surgeons assessed as requiring two or less years training to meet College equivalence;
- the number of overseas trained surgeons undertaking and/or completing training as specified by the College; and

- the outcome of any other assessments.

Information sought by each of the above dot points shall be broken down into the following categories:

- applicants with original qualifications from an English speaking country;
- applicants with original qualifications from a non-English speaking country but with further qualifications from an English speaking country;
- applicants with qualifications only from a non-English speaking country.

The College shall also publish annually a description of the assessment process (to the extent that the College does not do this already – for example, on its internet website).

Selection of trainees

C10: The College shall ensure that its selection processes for basic and advanced surgical training continue to be consistent with the Brennan principles (as set out in Attachment F).

Within one month of authorisation commencing, the College shall invite health ministers to nominate members to all panels (whether national or regional) selecting trainees for basic and advanced surgical training.

The College shall provide all applicants for basic surgical training with their decile ranking for their total selection score and for each individual component of their assessment.

The College should advise all unsuccessful applicants for advanced surgical training as to whether they were suitable for admission to the advanced surgical training program.

Finally, the College should provide written reasons to all unsuccessful applicants for basic surgical training and advanced surgical training if requested by these applicants.

C11: The College shall make public annually:

- the number of applicants for basic surgical training;
- the number of successful applicants for basic surgical training;
- the 'cut-off' score for basic surgical training (that is, the score below which applicants would not be eligible to enter training);
- the decile in which the lowest-ranked applicant accepted into basic surgical training fell;
- the number of basic trainees who have been appointed by individual hospitals;
- a statement of the criteria for, and a description of the process for selecting basic surgical trainees;

- the number of applicants for advanced training;
- the number of successful applicants for advanced surgical training;
- the 'cut-off' score for advanced surgical training;
- the number of advanced surgical training posts available by sub-specialty and hospital;
- the number of unfilled advanced (accredited) surgical training posts by sub-specialty (if any) and an explanation as to why in each case; and
- a statement of the criteria for, and a description of the process (including the weight given to each element of the process) for selecting advanced surgical trainees in each sub-specialty.

Limit on the number of basic surgical training posts

C12: Before finalising the limit on the number of basic surgical training posts for a particular year, and the distribution of these posts between states and territories, the College shall write to Commonwealth, state and territory health ministers:

- informing them of the limit it proposes to impose on the number of basic surgical training posts for the following year;
- explaining how this proposed limit has been calculated;
- informing ministers of the proposed distribution of basic surgical training posts by state and territory;
- explaining how this distribution has been determined; and
- inviting ministers to comment on the proposed limit on and distribution of basic surgical training posts within a reasonable specified period determined by the College, and take these comments into account when finalising the limit and distribution.

Training and examination

C13: The College shall make public annually:

- the number of basic surgical trainees in each year of training;
- the number of trainees successfully completing basic surgical training (and who therefore become eligible to apply for an advanced training position) and the number of these trainees who are in their second year of training, their third year of training and their fourth year of training;
- the pass rate for the MSQ and OSCE exams each time they are held;
- the number of advanced surgical trainees by sub-specialty and year of training;
- the number of trainees approved and not approved to undertake the Part 2 exam by

sub-specialty;

- the pass-rate for the Part 2 exam by sub-specialty;
- the number of trainees successfully completing advanced surgical training by sub-specialty;
- the number of new College Fellows by sub-specialty; and
- the number of trainees dismissed from basic and advanced surgical training by sub-specialty and the year of the course these trainees were in when dismissed.

The information required to be published in relation to each of the above dot points shall be published as both a national aggregate and by state or territory.

The College shall also make publicly available (to the extent that it does not already – for example, on its internet website) a summary of basic surgical training and advanced surgical training conducted in each year containing:

- the length of basic surgical training;
- a brief description of the subject matters covered in basic surgical training;
- a description of the educational courses required to be completed by basic surgical trainees;
- how basic surgical trainees are assessed during their basic training;
- a description of the Part 1 examination, including its various elements and the marking system used;
- the length of the training courses in each advanced training sub-specialty;
- a brief description of the subject matters of the training course in each sub-specialty;
- how advanced surgical trainees are assessed during their surgical training;
- the criteria used to determine whether a surgical trainee is eligible to sit the Part 2 exam in each sub-specialty; and
- a description of the Part 2 examination, outlining its various elements and the marking system used.

Specialist societies

C14: Sub-specialty societies involved in advanced surgical training shall act in accordance with College directions relating to advanced surgical training. The College shall also remain party to agreements with each sub-specialty society involved in advanced surgical training specifying the relationship, obligations, responsibilities and accountabilities of that society to the College. These agreements shall specify appropriate mechanisms for ensuring that the College exercises full direction and control over affiliated sub-specialty societies in relation to surgical

training. These agreements shall be publicly available (except as regards any financial matters which are reasonably deemed to be commercial-in-confidence).

Appeals

C15: Within one month of the authorisation commencing, the College shall write to the AHMC inviting it to nominate persons to sit on its appeals committee. At this time, it shall also nominate persons for consideration by the AHMC, which the AHMC may accept or reject.

If the AHMC nominates persons, the composition of the Appeal Committee shall be altered to comprise:

- a majority of members nominated by the Australian Health Ministers Conference (or a delegate); and
- a minority of members who are College Fellows from sub-specialties other than the one from which the appeal originated.

The College shall not accept as an appointed person to sit on its appeals committee, any person nominated by the AHMC who sits on any panel established in accordance with condition C6.

C16: Within three months of authorisation commencing, the College shall amend its grounds for appeal so that they are as follows:

- that an error in law or in due process occurred in the formulation of the original decision;
- that relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision;
- that irrelevant information was considered in the making of the original decision;
- that procedures that were required by College policies to be observed in connection with the making of the decision were not observed;
- that the original decision was made for an improper purpose;
- that the original decision was made in accordance with a rule or policy without regard to the merits of the particular case; and
- that the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

C17: The College shall retain an appeals process and, within three months of authorisation commencing, amend the relevant rules to:

- remove any rule providing for the awarding of costs against an appellant;
- require that successful appellants have their application fee refunded;

- provide the Secretary of the Appeals Committee with the power to waive the application fee in appropriate circumstances and giving the Chair of the Appeals Committee the power to review decisions of the Secretary on application of the appellant;

- require appellants to be provided with written reasons for an original decision within two weeks of requesting these reasons;

- require appeals hearings to be held within three months of the lodging of an appeal;

- allow appellants to be represented by a personal advocate, colleague or mentor in those cases where the Appeals Committee considers that an appellant could not, or would be disadvantaged in his or her appeal if required to present in person; and

- allow sponsoring hospitals to appeal on behalf of overseas-trained doctors they are seeking to employ.

The College shall continue to:

- require appellants to lodge appeals in writing within three months of receiving reasons for a decision;

- notify appellants in writing of the date, time and location of an appeal hearing at least 14 days before it is held;

- require appellants to lodge written submissions to the appeals committee a reasonable period of time before an appeals hearing;

- require the appeals committee to issue a written decision within three weeks of the appeal hearing, along with reasons for this decision;

- allow appellants to present their case themselves at an appeals hearing; and

- allow appellants to have legal representatives present at the appeals hearing as observers (rather than participants).

Information to remain publicly available until authorisation expires

C18: The information required to be made publicly available in conditions C4, C9, C11 and C13 shall remain publicly available until the relevant authorisation period expires.

Memoranda of understanding between the College and State and Commonwealth Governments

C19: The College shall use its best efforts to:

- establish memoranda of understanding with the Australian Health Ministers Conference or individual health ministers as practical and appropriate given the nature of the particular condition(s) being addressed in the memoranda;

- ensure that these memoranda set out efficient and appropriate processes for

implementing conditions C2, C3, C6, C10, C12, C15 and any other relevant condition of authorisation.

The College and the AHMC or individual health ministers may agree to include any other matter in the relevant memoranda.

Consumer involvement in College processes

C20: Within three months of the authorisation commencing, the College shall write to consumer groups including the Australian Consumers' Association, the Consumers Federation of Australia, and the Consumers' Health Forum of Australia seeking their views on the appropriate involvement of consumer representatives in the College's processes. The College should also consult other relevant interested parties, including health ministers (or their delegates).

The College shall then prepare a draft policy on consumer involvement in its processes and seek the views of interested parties (including the aforementioned consumer groups) on this draft. The College shall then publicly issue a final policy. This policy must be publicly available within 6 months of the grant of authorisation. A copy must also be provided to the Commission at this time. The College may request an extension of time from the Commission, which the Commission may grant.

Generally, the policy should identify opportunities for consumer group involvement on relevant committees, panels etcetera, as well as identify when consumer groups need to be consulted on broader policy issues.

Implementation of conditions

C21: Commencing in 2004, the College shall provide the Commission and health ministers with annual reports stating how it has implemented the conditions attached to this authorisation.

Interpretation of conditions

16.14 Any reference in a condition to the Australian Health Ministers Conference or health minister shall be interpreted as allowing the Conference or minister to delegate its role under the condition.

Other matters

16.15 If the AHMC (or delegate) chooses not to participate in the College's training and assessment processes as envisaged in this determination, the College's authorisation and the resultant immunity from legal action under the Act will not be affected.

16.16 Authorisation extends to all future College Fellows, as well as future members of the College's affiliated specialist societies and associations.

Period of authorisation

16.17 The Commission grants authorisation to the provisions of the arrangement pursuant to which the College administers processes for:

- selecting basic and advanced surgical trainees;

- training basic and advanced surgical trainees; and
- examining basic and advanced surgical trainees

for six years.

16.18 The Commission grants authorisation to the provisions of the arrangement pursuant to which the College administers processes for:

- assessing overseas-trained surgeons;
- accrediting hospitals for basic surgical training; and
- accrediting hospital posts for advanced surgical training

for four years.

Interim authorisation

16.19 The College has had interim authorisation for its training and assessment processes since the Commission's consideration of its application commenced. The protection afforded by interim authorisation has been extended until the Commission's final determination comes in to force.

16.20 Interim authorisation will continue to protect the proposed arrangements from action under the Act:

- where no application is made to the Tribunal for review of the Commission's determination, until the date that the Commission's final determination comes into effect;
- where an application is made to the Tribunal for review of the Commission's determination, until the day on which the Tribunal makes a determination on the review; or
- until the Commission, or the Tribunal in the event of an application for review of the Commission's determination, decides to revoke interim authorisation.

ATTACHMENT A

LIST OF SPECIALTY SOCIETIES ON WHOSE BEHALF AUTHORISATION IS SOUGHT

Neurosurgical Society of Australasia

Australian Orthopaedic Association

New Zealand Orthopaedic Association

Australian Society of Otolaryngology – Head and Neck Surgery

New Zealand Society of Otolaryngology – Head and Neck Surgery

The Australasian Association of Paediatric Surgeons

The Urological Society of Australasia

The Australasian Society of Cardiac and Thoracic Surgeons

The New Zealand Association of Plastic and Reconstructive and Aesthetic Surgeons

General Surgeons Australia

New Zealand Association of General Surgeons

Australian Society of Plastic Surgeons

Colorectal Surgical Society of Australia

Australian and New Zealand Society for Vascular Surgery

ATTACHMENT B

ASSESSMENT OF OVERSEAS-TRAINED PRACTITIONERS — SUMMARY OF RECOMMENDATIONS MADE BY THE COLLEGE, IN 2001

UNITED KINGDOM

6	**Exempt from Part 1:** Require 12 month period of assessment with oversight and upon satisfactory completion: • 1 would be eligible to sit for the Part 2 Exam; • 2 would be eligible to apply for Fellowship under Article 21; and • 3 are awaiting further recommendations dependent upon the outcome of the period of oversight.
3	Present directly to Part 2 Examination.
2	**Still in progress:** • 1 awaiting interview due to delay in requested information; and • 1 no letter of recommendation on file. Application cannot proceed without requested documentation.
2	Applications withdrawn.
2	Admission to Fellowship under Article 21.
2	Exempt from Part 1. Eligible to apply for advanced surgical training.
1	Eligible to apply to Fellowship under Article 21.
1	Applying for temporary specialist registration due to working in East Timor. College granted conditional vocational registration under oversight conditions.
1	Eligible to sit Part 2 Examination. Also needs to successfully complete Early Management of Severe Trauma course.

SOUTH AFRICA

4	**Exempt from Part 1:** • 2 required to undertake a successful period of assessment under oversight. Then eligible to sit the Part 2 Examination; and • 2 required to undertake a successful period of assessment under oversight. Then eligible for admission under Article 21.
2	Council ratified recommendation for admission under Article 21.
2	Further information required.
1	Application withdrawn.

INDIA

3	Required to successfully complete the Part Multiple Choice Question and Objective Structured Clinical Examination's and the Early Management of Severs Trauma course. Then will be eligible to apply to sit the Part 2 Examination.
2	Additional information requested. Application still in progress.
1	Awaiting interview.
1	Awaiting specialist assessment form from the Australian Medical Council and payment of fee.

1	Exempt from Part 1 except for the Early Management of Sever Trauma course. Required to undertake successful assessment under oversight and complete Part Examinations or apply for Fellowship under Article 21, depending on the recommendation arising from the period of oversight.

YUGOSLAVIA

2	Successfully complete the Part 1 Multiple Choice Question and Objective Structured Clinical Examination's and the Early Management of Severe Trauma course. Then will be eligible to apply for the Part 2 Examination.
2	Exempt from Part 1.
1	Required to undertake a successful period of assessment under oversight. Then eligible to apply for the Part 2 Examination.
1	Lateral entry granted into advanced surgical training.

EGYPT

4	Exempt from Part 1. Eligible to apply for advanced surgical training.
1	Additional information requested from applicant. Application still in progress.

UNITED STATES OF AMERICA

2	Successfully complete assessment under oversight. Then eligible for admission to Fellowship under Article 21.
1	Exempt from Part 1. Eligible to apply for advanced surgical training.
1	Awaiting feedback from Speciality Board.

IRAQ

1	Exempt from Part 1. Eligible to apply for advanced surgical training.
1	Awaiting specialist assessment for from the Australian Medical Council and payment.
1	Application withdrawn.

PAKISTAN

2	Successfully complete the part 1 Multiple Choice Questions and Objective Structured Clinical Examinations and Early Management of Severe Trauma course. Then will be eligible to apply for advanced surgical training.
1	Additional information requested.

CHINA

1	Successfully complete assessment under oversight. Then eligible to apply for Part 2 Examination.

1	Must successfully complete Early Management of Severe Trauma course and Objective Structured Clinical Examination. Then will be eligible to apply advanced surgical training.

POLAND

1	Exempt from Part 1. Eligible to apply for advanced surgical training.
1	Application withdrawn.

SRI LANKA

2	Exempt from Part 1. Eligible to apply for advanced surgical training.

SWEDEN

1	Exempt from Part 1. Required to undertake a successful period of assessment under oversight. Then eligible to apply for Part 2 Examination.
1	Awaiting specialist assessment form from the Australian Medical Council.

AUSTRIA

1	Needs to successfully complete Early Management of Severe Trauma course and undertake a successful period of assessment under oversight. Then eligible to apply for Part 2 Examination.

BOSNIA

1	Exempt from Part 1. Lateral entry into advanced surgical training.

BULGARIA

1	Awaiting specialist assessment form from the Australian Medical Council.

BURMA

1	Exempt from Part 1. Eligible to apply for advanced surgical training.

ETHIOPIA

1	Required to successfully complete Part 1 and Part 2.

GERMANY

1	Period of successful assessment under oversight. Then eligible to apply for Part 2 Examination.

ISRAEL

1	Exempt from Part 1. Eligible to apply for advanced surgical training.

MALAYSIA

1	Required to undertake a successful period of assessment under oversight. Then eligible to apply for the Part 2 Examination.

MEXICO

1	Required to undertake a successful period of assessment under oversight. Then eligible to apply for Part 2 Examination.

RUSSIA

1	Required to complete Part 1 and Part 2.

SUDAN

1	Additional information requested. Application still in progress.

SWITZERLAND

1	Exempt from Part 1. Requires successful period of assessment under oversight to determine whether eligible to apply for the Part 2 Examination.

TURKEY

1	Exempt from Part 1. Requires successful period of assessment under oversight to determine if eligible to apply to apply for the Part 2 Examination.

VIETNAM

1	Application withdrawn.

ATTACHMENT C

PAPER BY PROFESSOR BORLAND

Is the supply of specialist surgeons in Australia adequate?

Professor Jeff Borland

Department of Economics

University of Melbourne

October, 2002

Executive summary

1. The main objective of this report is to assess the adequacy of the supply of surgeons in Australia. That assessment is made by examining whether each surgical workforce market is in balance, in shortage or in surplus at the time of the most recent Australian Medical Workforce Advisory Committee (AMWAC) report into that workforce, and whether there has been any apparent tendency to surplus or shortage in each workforce in the time period since the report. Adequacy is assessed on the basis of whether current supply appears to be sufficient to provide minimum acceptable health level outcomes for society, and to meet current demand for services.

2. In this report a specialist surgical workforce will be defined as members of a specialist surgical association or society, or surgeons with an advanced qualification currently practicing in that area. Nine surgical workforce areas are identified - General surgeons; Cardiothoracic surgeons; Neurosurgeons; Orthopaedic surgeons; Ear, nose, throat (ENT) surgeons; Paediatric surgeons; Plastic surgeons; Vascular surgeons; and Urologists. (But due to data limitations, analysis of workforce adequacy can only be undertaken for seven of those groups.)

3. From a social welfare, or public benefit perspective, there are two main dimensions of supply on which it seems that an assessment of adequacy should focus. The first issue is - Is the size of a specialist surgical workforce such that the amount of surgical services provided by the workforce is adequate? The second issue is – Are the work patterns of the specialist surgical workforce such that the distribution of surgical services provided by that workforce is appropriate? In this report the main emphasis in the assessment of adequacy will be on the total size of a specialist surgical workforce. This is on the basis that the primary effects of RACS and specialist surgical associations/societies on supply of surgical services will come via their impact on the total number of specialists with advanced training qualifications in surgery. That potential effect on the total workforce size occurs through the role that RACS and the specialist surgical associations/societies have in - the creation of accredited training places; the selection of trainees; and examination of surgical trainees.

4. The report reviews possible approaches that can be applied to assess adequacy. One approach to assessing adequacy of the total size of a specialist surgical workforce is to examine whether the current labour supply is consistent with the benchmark of efficiency. For example, a direct approach would compare the current labour supply of a specialist surgical workforce group with the efficient level of labour supply for that group. It is concluded that at present it is not feasible to apply this type of approach. A second approach to assessing adequacy of the total size of a specialist surgical workforce is to examine whether the current labour supply meets current 'population requirements'. One interpretation of population requirements is in terms of the health status of the population. An alternative interpretation is related to current demand for services. In this report it is proposed that the methodology to assess adequacy should be an amalgam of the two types of 'population requirements' approaches. In circumstances where current demand or minimum health standards reflect the social value of services of a specialist surgical workforce then this approach will also incorporate an assessment of adequacy against the standard of efficiency.

5. Empirical analysis of the adequacy of the surgical workforce that is undertaken in the report involves two elements. First, to the extent possible, the suggested 'amalgam' population requirements approach for assessing adequacy is applied. This requires use of data on each specialist surgical workforce from AMWAC reports, and hence applies to the date at which data were collected for the respective report. (Limitations on the scope to apply

the proposed methodology derive from data limitations. Only a restricted set of indicators of workforce adequacy is available from AMWAC reports, and there is not sufficient data available to distinguish between the role of workforce size and other factors on those indicators.) Second, an analysis is undertaken for each specialist surgical workforce of estimated changes in demand, and forecast changes in supply, in the period since its respective AMWAC report. This provides a perspective on whether there is likely to have been any tendency to shortage or surplus in each market.

6. The empirical analysis of specialist surgical workforce adequacy undertaken in the report suggests that – against the criteria of whether workforce size is sufficient to provide minimum acceptable standards of health care and to meet current demand - at present in Australia those workforces fall into three main categories –

1. Strong likelihood of current shortage: Urology, ENT surgery.

2. Likelihood of shortage: General/vascular surgery; Orthopaedic surgery.

3. Marginal likelihood of shortage/Limited evidence to make assessment: Neurosurgery; Cardiothoracic surgery.

The three categories of likelihood of workforce shortage have been chosen to distinguish different degrees of confidence that it seems should be attached to the probability of workforce shortage. The judgement on which category is appropriate for a specific workforce reflects two main considerations – first, the number of indicators that are available to assess workforce adequacy for that specific workforce; and second, the type of evidence from the available set of indicators. In interpreting these conclusions on workforce adequacy one important point to note is that the degree of likelihood of a workforce shortage for a specific surgical workforce should not necessarily be taken as a signal of the public policy importance of alleviating that shortage – that will depend both on the likelihood that a shortage exists and on the social losses that are imposed by a workforce shortage in each specialty surgical area.

1. Introduction

The main objective of this report is to assess the adequacy of the supply of surgeons in Australia. This task is undertaken in two main stages. First, it is necessary to define adequacy and an empirical methodology for assessing whether supply meets that standard of adequacy. This is a general exercise that should have value for future research and policy analysis on labour markets for medical specialists in Australia, as well as providing context for the analysis in this report. Second, empirical analysis of the adequacy of the size of specialist surgical workforces in Australia is undertaken. That analysis assesses whether each specialist surgical workforce market is in balance, in shortage or in surplus at the time of the most recent Australian Medical Workforce Advisory Committee (AMWAC) report into that workforce, and whether there has been any apparent tendency to surplus or shortage in each workforce in the time period since the report. Adequacy is assessed on the basis of two criteria:

(i) Whether current supply appears to be sufficient to provide minimum acceptable health level outcomes for society, and (ii) Whether current supply appears to be sufficient to meet current demand for services.

The report is structured as follows: Section 2 provides background information on the scope of labour markets for specialist surgeons. Section 3 describes the main determinants of the supply of surgeons in Australia. Section 4 describes and evaluates alternative approaches to assessing the adequacy of supply. Section 5 reviews evidence on the adequacy of supply for the main specialist surgical labour markets in Australia.

In preparing this report two main sources of information have been consulted. First, the primary source of data on which judgements are made about adequacy of supply is from AMWAC reports on surgical workforce groups. Second, in order to decide on an appropriate methodology for assessing adequacy of supply, a variety of previous studies of markets for medical specialists in Australia have been reviewed – for example, AMWAC (2000a), AMWAC Review Team (2002), Baume (1994), Borland (2001, 2002), Chapman and Ryan (2001), Commonwealth Department of Health and Aged Care (2001), and Hall and Van Gool (2000).

2. Background

a. Surgical workforce groups

In this report the issue of adequacy of supply will be examined for specialist surgical workforce groups in Australia. A specialist surgical workforce will be defined as members of a specialist surgical association or society, or surgeons with an advanced qualification currently practicing in that area. Nine surgical workforce areas are identified - General surgeons; Cardiothoracic surgeons; Neurosurgeons; Orthopaedic surgeons; Ear, nose, throat (ENT) surgeons; Paediatric surgeons; Plastic surgeons; Vascular surgeons; and Urologists. (The website of the Royal Australasian College of Surgeons (RACS) also lists colorectal surgery and ophthalmologic surgery as surgical specialties. However, since advanced training in the former area is undertaken by RACS as part of the general surgery training program, and in the latter area is the responsibility of the Royal Australasian College of Opthalmologists, therefore these workforce groups are not specifically considered in the report.)

The taxonomy matches the division of the surgical workforce in Australia between specialty training areas. This seems a sensible approach - first, because in the current policy context of

an application by RACS for authorisation, what is ultimately of interest is whether supply of surgeons who have undertaken advanced training in each specialty area is adequate; and second, to match with available literature and data on the surgical workforce in Australia. (AMWAC reports on specialist medical workforces have generally used the same demarcation between specialist surgical labour markets as RACS.)

In adopting this approach it is important, however, to bear in mind that the labour of surgeons is demanded for the service of surgery that the workforce group can provide. (More generally, demand for labour is always a derived demand – that is, labour is not demanded for its own sake, but for the services it provides. The same point applies in the case of surgeons.) Recognising that it is the service of surgery, and not surgeons 'per se', that are being demanded, has important implications for the exercise of assessing adequacy of supply. It means that, ultimately, what is of concern is adequacy of supply of surgical services in Australia. The issue of adequacy of supply of specialist surgeons is only relevant in that the number of surgeons is a prime determinant of adequacy of supply of services.

One implication is that it is necessary to be aware that there may be other suppliers of the type of services provided by a specialist surgical workforce group (Baume, 1994, p.23). These alternative suppliers may be members of other specialist surgical associations or societies – for example, general surgeons are quite likely to engage in paediatric surgery, urology, and orthopaedic surgery (see AMWAC, 1997a, p.30) – or might be General Practitioners (GPs). Since what is of interest is adequacy of supply of surgical services, an assessment of adequacy of supply of members of a specialist workforce group must take into account the existence of those alternative suppliers. For example, suppose demand for the service of paediatric surgery increases, but that there is no increase in labour supply by members of the Australasian Association of Paediatric Surgeons (AAPS). This should not immediately result in a conclusion that supply of paediatric surgeons is inadequate – since it may be that alternative suppliers such as general surgeons have increased their labour supply in response to the growth in demand. Of course, having a lower proportion of specialist surgical services provided by suppliers with an advanced training in that area might potentially have other consequences – such as for quality.

A second point relates to the possibility that services provided by members of a specialist surgical workforce group may not perfectly overlap. This seems relevant in the context of a trend to sub-specialisation whereby a surgeon may only undertake a limited range of procedures from the set of services that would generally be considered to constitute the area of practice of that specialty workforce. It is an issue that is of considerable importance in assessing adequacy of supply. For example, suppose that consumers demand two types of service from members of a specialist surgical workforce – service A and service B. Suppose that there is demand for 100 hours of each service. Assume also that there are suppliers who can supply 200 hours of service A, but no suppliers exist for service B. Then a workforce definition that includes suppliers of both services A and B as being in the same group will show that demand and supply are perfectly balanced (200 hours of labour demand and labour supply); and the imbalance in the availability of surgeons to provide service B will be obscured. But if suppliers of service A and of service B are classified in separate workforce groups, then the imbalance between supply and demand will be evident. The point being made here is that assessments of the degree of balance between demand and supply in a workforce area are likely to be sensitive to definition of the scope of the workforce group or market.

b. Descriptive information

Background descriptive information on surgeons in Australia is presented in Tables 1-3. The descriptive information is derived from published data from the Australian Institute of Health and Welfare (AIHW) Medical Workforce Survey and from Medicare data.

Table 1 shows the distribution of the surgical workforce by main area of practice. It is evident that there is substantial variation in sizes of the different surgical workforce groups. Together, general surgeons and orthopaedic surgeons account for about 60 per cent of the workforce. ENT surgeons, plastic surgeons, and urologists account jointly for just over 25 per cent of the workforce. And the remaining surgical specialty areas account for about 15 per cent of the workforce.

Table 2 shows the total number of Medicare providers of surgical services. Several points of interest emerge from this Table. First, in 1998 there were about 3800 specialist Medicare providers of surgical services. This compares with the estimate of 2938 surgeons from the AIHW Medical Labour Force survey (Table 1). The disparity seems to indicate that there are a relatively large number of non-surgeon specialist Medicare providers of surgical services. At the same time there are also about 1200 non-specialist Medicare providers of surgical services, which is around 20 per cent of total Medicare providers of surgical services. Of course, data on numbers of different types of providers will not necessarily reflect the share of services provided by each type, since hours spent on surgical activities are likely to differ by type of provider. For example, specialist surgeons are likely to spend almost 100 per cent of their time in providing surgical services, whereas other providers can be classified as surgical service Medicare providers where any amount more than 50 per cent of their total Medicare billing is from surgical services. As well, non-specialist surgical service providers (such as GPs) are likely to be mainly involved in non-core surgical activities such as assistance at operations. It is worth noting that data from AMWAC reports generally show much smaller differences between numbers of surgeons using Medicare provider data, AIHW Medical Workforce data, and data on society/association membership. For example, Table 3 shows that – for at least four of the six workforce groups for which data are available – the number of members of the relevant surgical association/society is a fairly accurate measure of the number of providers whose main billing area is in that area of activity. Hence the available data do not offer an unambiguous conclusion on the relative shares of specialist surgical activity that is undertaken by specialists with an advanced training in that area and other medical practitioners. Nevertheless, the discussion does confirm the general importance of being aware of potential alternative suppliers to a specialist surgical workforce group.

The other main point from Table 2 is that there has been steady growth in the total number of Medicare providers of surgical services during the 1990s. Surgeons as a percentage of total Medicare providers have also grown over that period – although the main source of growth has been non-specialist providers of surgical services.

Table 4 presents data on per capita use of Medicare services during the 1990s. At the end of the 1990s the average number of specialist attendances was about 1 and operations about 0.3; out of total Medicare services of 5.4. The rate of growth in per capita specialist attendances and operations was slightly higher than for all services over the 1990s.

3. Sources of supply of surgical workforce and surgical services

This section describes the sources and determinants of supply of specialty surgical workforces and services. The workforces that are the focus of this report are surgeons who are members of a specialist surgical association or society, or with an advanced qualification,

currently practicing in that area. Hence the first sub-section describes the process by which the size of that specialist surgical workforce is determined. The second sub-section considers the more general issue of the supply of services to a specialty surgical area.

a. Supply of surgical workforce

The stock of RACS Fellows in each specialist association/society at any point in time is determined by inflows and outflows that have occurred in previous time periods. Inflows to the stock can occur through a training program or immigration. By far the most important component is entry through the training program. Outflows from the stock occur through emigration and retirement.

There are two stages in a surgical training program. In the first stage all trainees undertake two years of basic surgical training. In the second stage trainees undertake advanced training in a specialty surgical area. The length of the second stage is between four to six years (for example, four years for ENT, five years for neurosurgery, and six years for cardiothoracic surgery). In Australia AMWAC has responsibility for making recommendations on the number of training positions in each specialty area. With reference to surgical workforce groups it seems that thus far AMWAC has examined, and made recommendations on training positions for, seven of the nine specialty surgical areas (AMWAC, 1996, 1997a, 1997b, 1999, 2000b, 2001a). However, AMWAC does not seem to have considered the first stage of entry to basic surgery training.

Selection of trainees to fill the available first-stage training program positions from the pool of applicants, and advanced training positions in accredited hospital posts, are the responsibility of RACS. Trainees and most immigrants seeking to become Fellows of RACS need to successfully complete a training program and a 'Part II' examination in order to be approved for Fellowship (see for example, AMWAC, 2000b, p.27).

Applications to enter speciality areas are likely to be influenced by a range of factors. One set of factors will be economic incentives. Medical specialist incomes are made up of patient fees – rebates from the Commonwealth government through the Medicare system, insurance and workers compensation payments, and patient above-rebate (gap) payments; and payments from State governments for attendance at public hospitals. Paterson (1994, p.11) suggests that the key dimension of economic incentives derive from the Medicare system – specifically, which type of healthcare services attract a rebate, the size of rebate for different services, and method of payment. It is suggested that this set of factors can, for example, explain why there is excess supply to enter surgical specialties, and why there is excess demand in specialty areas with limited private practice opportunities (such as geriatrics). Another dimension of economic incentives may be the size of professional indemnity premiums required to work in different specialty areas. For example, growth in premiums for neurosurgeons has been suggested as one factor explaining a relatively low preference of new medical graduates to work in that area (AMWAC, 2000b, p.28).

The other set of factors that will affect supply are to do with non-pecuniary aspects of training programs and work. One type of factor is the time requirements for undertaking a training program. For example, programs differ in the scope they allow for part-time training and interruptions to training. Females' supply decisions show a preference for areas such as paediatrics that do allow part-time study (AMWAC, 1998, p.44). The same factor is likely to be important in explaining the low representation of females in specialty surgical workforces. A further factor in choices between specialty areas may be the degree of work-related stress. This might for example be an explanatory factor for shortages of new entrants in areas such

as neurosurgery (AMWAC, 2000b, p.28).

b. Supply of surgical services

Figure 1 shows the main sources of supply of surgical services. The source of supply that is the focus of this study is from Fellows of the RACS. Surgical services can also be provided by other types of specialists, or by non-specialists such as GPs. Surgical services (consultations/procedures) can be provided in either the public or private system. (Medical specialists who work at public hospitals can be of two main types: a visiting medical officer (VMO) who would be paid on a sessional basis for care of public patients but would predominantly work in fee for service private practice; and staff specialists who are salaried employees of public hospitals but retain some rights to private practice - Hall and Van Gool, 2000, p.198). Another source of supply of specialist services is by trainees working (primarily) in public hospitals – such trainees may be in accredited or non-accredited positions. Non-accredited positions do not provide an entitlement to sit for examinations for entry to membership of the RACS.

An important issue regarding supply of surgical services is the distinction between providers who are and are not entitled to Medicare rebates at the specialist level. The Australian Medical Council (AMC) makes recommendations to the Health Insurance Commission (HIC) on necessary qualifications for practitioners to have that status. Based on evidence from the National Specialist Qualifications Advisory Committee (predecessor of AMC), Baume (1994, p.109) argues that recognition '...requires a qualification, obtained by examination, being one that must be awarded by, or equate to that awarded by the relevant specialist professional college in Australia'. Hence patients of members of RACS would generally be entitled to specialist rebates for provision of surgical services. Other practitioners may also have specialist rebate entitlement in some circumstances; in other circumstances those practitioners may provide substitute services to specialist surgeons but without entitlement to rebates.

4. How to assess adequacy of supply?

a. Dimensions of supply

From a social welfare, or public benefit perspective, there are two main dimensions of supply on which it seems that an assessment of adequacy should focus:

- Is the size of a specialist surgical workforce such that the amount of surgical services provided by the workforce is adequate?

- Are the work patterns of the specialist surgical workforce such that the distribution of supply of surgical services provided by that workforce is appropriate?

Aspects of the distribution of services that are of particular concern are the ability of individuals with different levels of income, and living in different regions (rural/city), to access and consume services provided by specialist surgeons. So, for example, 'work patterns' could refer to the allocation of a specialist surgeon's time between public and private practice, or to the geographical distribution of specialist surgeon's practices.

In this report the main emphasis in the assessment of adequacy will be on the total size of a specialist surgical workforce. This is on the basis that the primary effects of RACS and specialist surgical associations/societies on supply of surgical services will come via their impact on the total number of specialists with advanced training qualifications in surgery. That potential effect on the total workforce size occurs through the role that RACS and the

specialist surgical associations/societies have in - the creation of accredited training places; the selection of trainees; and examination of surgical trainees. By contrast, the actions of RACS do not seem likely to have the same direct consequences for distributional outcomes. For example, a finding that the distribution of specialist surgical services was unequal between households with different income levels would not necessarily be any reflection of the direct effects of RACS on the surgical workforce. It would be much more likely to represent, for example, the effects of incentives to practice in the public and private systems due to the Medicare system and levels of public hospital funding. (Of course, there may be indirect effects of RACS on distribution between households. For example, a surgeon's capacity to charge above-rebate fees in the private system, and hence the incentive to practice in that system, may be related to total supply, and therefore potentially to the effect of RACS on the total workforce size.)

In the context of the application for authorisation by RACS, it does seem most appropriate to focus on that dimension of adequacy – total workforce size - that is directly affected by the actions of RACS and the specialist surgeon associations/societies. However, one aspect of the distribution of surgical services that will be considered is the geographic distribution. This is because information on the geographic distribution can be informative about the adequacy of total supply. For example, one manifestation of a workforce shortage may be a significant imbalance between the Surgeon/Population ratios in urban and rural areas. And importantly, it does seem that RACS can have some influence on the geographic distribution of services – through, for example, decisions on which hospitals will have 'accredited training unit' status as locations where surgical training can occur – see AMWAC, 2000b, p.27).

An assessment of the adequacy of supply on the criteria of the total number of specialist surgeons ignores the issue of quality. Of course, quality of specialist surgical services should also be an important criteria for assessing adequacy. However, there is little available data on quality of services. Hence, for that reason the issue of adequacy of quality will not be directly addressed in this report.

b. Possible approaches for assessing adequacy of total supply

i. Comparison to optimal outcomes

One approach to assessing adequacy of the total size of a specialist surgical workforce is to examine whether the current labour supply is consistent with the benchmark of efficiency. There are direct and indirect approaches for evaluating efficiency.

Direct approach

The direct approach is to compare the current labour supply of a specialist surgical workforce group with the efficient level of labour supply for that group. Current labour supply can be calculated as the current number of specialist surgeons or current hours of work of that workforce. The efficient level of labour supply is that level necessary to produce the efficient amount of surgical services in a specialist area. To achieve the efficient level of services requires production of any 'unit' of a service for which the value society derives from consumption of that unit exceeds the cost to society from production of the unit. Hence, in order to estimate the efficient labour supply it is necessary to know the efficient level of service provision. That requires being able to estimate the value that individual consumers place on specialist surgical services, the extra value that society might place on those services due to 'external effects', and the costs to surgeons and to society of providing those services (training costs and opportunity cost of supplying the services). This represents a

very significant informational requirement in order to implement the direct approach to assessing efficiency, and hence, at least in the immediate future, such an approach does not seem feasible.

Indirect approaches

One indirect approach to assessing whether the current supply of a specialist surgical workforce is efficient would be to estimate the rate of return on training for that group, and to make a comparison against returns for other professional workforce groups. The main idea underlying this approach is that the existence of a competitive market can be equated with an efficient level of supply. In this case suppose a workforce group can be found for which the market outcome is regarded as 'competitive', and hence consistent with an efficient supply of services in that market. Then with free entry to occupations it should be the case that, if the supply of specialist surgical services is efficient, the rate of return will be equivalent in the medical and the benchmark labour markets. Some difficulties exist with application of this method. First, it may be difficult to find a counter-factual labour market that represents the efficient benchmark. Second, there is a range of practical difficulties in implementing the method – for example, most specialist surgical workforce groups will have significant capital outlays so that income to those groups involves a return to labour and capital assets.

Another indirect approach is conduct-based. This involves analysis of whether there are practices or outcomes in the specialist surgical market that depart from what would be expected in a competitive market. (Again, the existence of a competitive market is equated with an efficient level of supply of surgical services.) One example of this approach would be from the United States where there has been considerable attention given to bans on advertising by medical practitioners that are enforced by the American Medical Association, and on the effects of those bans on price. Other examples of conduct that might provide insights to the degree of competition would be: the degree of sensitivity of prices of services to changes in the market environment; whether price structures, such as charging a single fee to cover consultations and procedures in some areas, would be sustainable in a competitive market; and the degree to which conduct by surgical specialist workforce groups excludes other practitioners from providing a substitute service. One problem with this approach is that it is likely to be difficult to specify precise conduct standards that would be expected to exist in a hypothetical benchmark efficient market. A second issue is that – even if the method can be used to identify a shortage of specialist surgical providers relative to an efficient benchmark – it will not provide information on the magnitude of that shortage.

ii. Comparison to 'population requirements'

A second approach to assessing adequacy of the total size of a specialist surgical workforce is to examine whether the current labour supply meets current 'population requirements'. This is the approach that is applied by AMWAC in its assessment of medical workforce adequacy. (For example, in its report on the neurosurgery workforce (AMWAC, 2000b, p.1) is it stated that "In compiling this report, the Working Party adopted the following underlying principles: the Australian community should have an adequate number of trained neurosurgeons, appropriately distributed *to provide the surgical services it requires*".)

In order to apply this approach it is necessary to specify what is meant by 'population requirements' (Hall and Van Gool, 2000). One interpretation would be in terms of the health status of the population. An alternative interpretation would be related to current demand for services.

Minimum acceptable health levels

With the health status interpretation, population requirements could be taken to mean a benchmark level of services from a specialist surgical workforce that it is estimated would be required for the population to achieve and maintain defined minimum acceptable health levels.

One way to implement this approach is to estimate the level of labour supply of the specialist surgical workforce required to achieve the minimum health standard, and make a comparison with the actual level of available supply. The main problems with this approach are choosing the benchmark minimum acceptable health level; and estimating the set of services, and labour supply requirement per service, for each specialist surgical workforce in order for the population to achieve the minimum health level.

An alternative approach using minimum health levels to represent population requirements would be to examine indicators that allow indirect inferences to be made on the adequacy of a specialist surgical workforce. Some main indicators that might be used in this way would be – surgeon/population ratio; waiting list length for urgent conditions; distribution of hours of work of specialists; share of specialist surgical services provided by practitioners with advanced surgical training; and geographic distribution of specialist surgeons. For example, for each given area of specialty surgery it should be possible to set a standard for the minimum time within which patients classified as 'urgent' should have an initial consultation; that a significant fraction of urgent patients are not having an initial consultation within that time would then be evidence of not meeting minimum health levels. Or, a maximum number of hours that a specialist surgeon can work per week and provide acceptable levels of care could be specified; where a significant proportion of surgeons are working more than that number of hours, again, this could be taken as evidence that minimum health standards are not being met. Note that this approach gets around the problem of having to work out how much labour supply by surgeons is necessary to achieve minimum health standards; but it does not get round the problem of needing to say what are those standards – since, for example, specifying the maximum allowable waiting time for urgent patients requires an implicit assumption on minimum health standards in society. [As Baume (1994, p.24) notes "Any estimate of 'desirable' or 'correct' rates of surgery is value-dependent and has no absolute validity".]

Current demand

Interpreting population requirements in terms of current demand, the central question is whether the current labour supply, and hence supply of services in a specialist surgical area, is sufficient to satisfy current demand for that type of specialist surgical service. To answer this question requires a method for comparing current supply and current demand. But that method cannot be to treat current demand as equivalent to current service usage. This is because – regardless of whether there is a surplus, shortage, or equilibrium – the current supply of services will equal current service usage. Most particularly, where there is a shortage of supply, then current demand is greater than current supply – but only the amount of demand that can be satisfied by current supply will be observed; the residual demand will be 'latent' or unobserved. Hence, an alternative approach is required. What is necessary is to find other 'signals' of the degree of balance between supply and demand.

One way of doing this is to consider the nature of adjustment in markets for specialist surgeons. Where there is a change in demand for services in a specialist surgical area but no change in the number of specialist surgeons in that area, this should be manifested in

adjustment mechanisms in the market. In markets for medical specialists there would seem to be a variety of adjustment mechanisms – a) Number of accredited trainees; b) Number of non-accredited trainees; c) Immigration; d) Hours of work; e) Geographic distribution of the workforce; f) Distribution of total output of surgical services in a specialist area between practitioners with and without advanced training; g) Price of services; and h) Waiting list length (Borland, 2002). So, for example, where there is an increase in demand and no change in workforce numbers in a specialist surgical area, it would be expected that this should cause some type of adjustment – such as higher prices, or longer waiting lists - than would otherwise exist. Hence, the approach derived from a consideration of adjustment mechanisms in a market is to examine those mechanisms to find if they reveal evidence of an imbalance between supply and demand.

A first difficulty with this approach is that it does not seem possible to make conclusions on whether a shortage or surplus in the number of specialist surgeons in a workforce area exists at a point in time. To make such a judgement would require specifying benchmark levels of – for example – prices and waiting lists for which it would be concluded that a market exhibited a shortage of supply, balance between supply and demand, and surplus of supply. But in the absence of a detailed econometric model of each specialist surgical market, this does not seem feasible.

Instead, what appears feasible is to apply the indicators in a way that would reveal whether – over time – there is a tendency to a shortage or surplus of a specialist surgical workforce group. This would involve analysis of data on time-series changes in the adjustment mechanisms in a specialist surgical market and comparison of changes between markets. For example, suppose for specialist market A it is found that between 1995 and 2000 there has been no change in the number of specialists with advanced training (despite population growth) but that there have been large increases in the price of services and waiting lists; whereas in market B over the same period there has been growth in the number of specialists with no changes in prices of services or waiting list length. Then this could be seen to provide evidence of a tendency to shortage in market A. (Of course, since it is not possible to characterise shortage or surplus at a point in time, it might be argued that what had occurred in market A was the 'undoing' of a surplus that existed in 1995.)

A second issue with implementing this approach is that since there are multiple adjustment mechanisms in a market, to develop an appropriate perspective, the analysis would need to consider multiple indicators. There is then the question of how those indicators would be aggregated to form an overall opinion on whether there was a tendency to shortage or surplus in a market. There is no algorithm or formula that can be easily applied to accomplish that aggregation – this would seem to be an area where judgement is required.

c. An alternative suggested approach

An alternative approach – that is an amalgam of the two types of 'population requirements' approaches described above – can also be proposed. The reason for suggesting this approach is pragmatic – that for policy-makers the issue of whether the number of surgeons is adequate is likely to be both about having enough surgeons to provide what society regards as minimum acceptable health standards, and enough surgeons to meet current demand for surgical services.

With this 'amalgam' approach there would be two components to analysis of adequacy of specialist surgical services:

a. Analysis of whether supply of specialist surgeons with advanced training is

sufficient to allow provision of minimum acceptable health standards. This analysis would involve examining 'point-in-time' indicators such as waiting list length for urgent conditions, and working hours of specialist surgeons. The main requirement is for judgements on what levels of those indicators are equivalent to minimum health standards.

b. Analysis of whether market adjustment indicators suggest that there is a tendency to shortage/surplus of specialist surgeons with advanced training. This analysis would involve examining time-series changes in variables such as average price of services, waiting list length, geographic distribution of specialist surgeons, and making comparisons between different specialist areas. The main requirement is for judgement on how the set of indicators should be interpreted to arrive at a conclusion that a shortage or surplus exists.

Interpretation of any indicators must be sensitive to the range of factors that might affect each indicator. Each indicator may to some extent reflect effects of size of the specialist surgical workforce, but may also be influenced by other factors. One example is noted in Baume (1994, p.36) that "...waiting lists are due to combinations of factors, only some of which relate to surgeons" (for example, hospital funding). Therefore, in seeking to make inferences from indicators such as waiting list length on effects of workforce size on, for example, adequacy of the level of health care in Australia, it is important to attempt to distinguish between the effects of workforce size and the effects of determinants of waiting list length. Another example would be the geographic distribution of specialist surgical services. In interpreting this indicator it is important to take into account that a geographic imbalance may be a reflection of an overall shortage but may also to some extent reflect that a minimum population is required within any geographic 'catchment' area in order for a specialist service to be sustainable within that area.

The indicators required to implement the approach should be able to be constructed without too much difficulty from existing data sources. For example, the average price of a standard 'basket' of services provided (under Medicare) by a specialist surgical workforce group for different years should be able to be constructed from Health Insurance Commission (HIC) data. As another example, data on working hours of specialist surgeons is available from the workforce survey that is undertaken on an annual basis by the AIHW.

In considering this alternative suggested approach it is important to recognise that the exercise of assessing current supply against standards of minimum acceptable health standards or current demand it not necessarily related to the question of whether current supply is at an efficient level. Only in circumstances where current demand or minimum health standards reflect the social value of services of a specialist surgical workforce would such a relation hold. One reason however for thinking that such a relation might exist is where it is believed that government intervention in the market for medical services (for example, through subsidies to the cost of medical treatment) is designed to induce levels of demand that are socially optimal – that is, to correct for market failures that would otherwise exist.

5. Is the supply of surgeons adequate?

In this section the empirical issue of whether the current supply of specialist surgeons in specific workforce areas in Australia is adequate will be addressed. A suggested approach for making this assessment has been proposed in the previous section. Unfortunately, limitations in published data mean that it is not possible to fully apply that method in this report. (Although, to reiterate the point made above – It would not be difficult to construct from existing data sources the type of measures that are proposed.)

The approach to assessing adequacy of the surgical workforce that is undertaken involves two elements. First, to the extent possible (given limitations described in the preceding paragraph), the suggested approach for assessing adequacy is applied. This requires use of data on each specialist surgical workforce from AMWAC reports, and hence applies to the date at which data were collected for the respective report. Second, an analysis is undertaken for each specialist surgical workforce of estimated changes in demand, and forecast changes in supply, in the period since its respective AMWAC report. This provides a perspective on whether there is likely to have been any tendency to shortage or surplus in each market.

Since the empirical analysis requires data from AMWAC reports, it is only possible to analyse those specialist surgical areas for which such reports have been prepared. This means that the paediatric surgery and plastic and reconstructive surgery workforces cannot be considered. However, from Table 1 it can be seen that those workforces account for only about 10 per cent of the total surgical workforce in Australia.

The main predecessor of the analysis in this report (leaving aside the AMWAC reports) is the Baume report (1994). It had amongst its Terms of Reference to (p.15) "...identify current and potential problems in the level of availability, accessibility and quality of these [surgical specialist] services". The Baume report made a strong conclusion on the issue of adequacy of the size of specialist surgical workforces (p.15):

"There are shortages in absolute numbers of surgeons, overall and in specific surgical specialties....There is an absolute lack of most groups of specialist surgeons, particularly urologists...There are also lacks of surgical practitioners in public hospitals at least in: ENT; orthopaedics; urology; ophthalmology; and shortages, particularly in these specialties, in non-metropolitan Australia."

The analysis in this report differs from that in the Baume report in several ways. First, the assessments of adequacy are based on more recent data available from AMWAC reports. Second, whereas the assessments of adequacy in the Baume report were based almost exclusively on a comparison of actual and 'desirable' surgeon/population ratios, the availability of a wider range of data from AMWAC reports means that in this report a broader set of indicators can be applied.

a. Urology

There is some evidence that a shortage existed in the market for urologists at the time of the AMWAC report (1996). On the criteria of requirements for achieving minimum health status outcome, a variety of indicators suggest that conclusion. First, Table 5 shows that the surgeon/population ratio at the time of the AMWAC report was below that specified as 'desirable' by the Baume report by a very large margin. Second, the public hospital vacancy rate for urologists is relatively high. Third, although it is argued in the AMWAC report (1996, p.4) that average waiting times for urgent patients for consultation/surgery are reasonable, other evidence (AMWAC, 1999, pp.27-28) shows that in 1995 urology patients with urgent conditions had waiting times for surgery and clearance time that were higher than any other speciality group.

There also appear to be grounds for concluding that – if it did not already exist in 1996 – a shortage of urologists is likely to have developed since that time. The main reason is that the assumed rate of growth in demand for urological services, on which recommendations on the number of training positions in urology are based that would be needed to satisfy demand were based, seems too low. The assumed rate of growth in demand is 1.6 per cent per annum (AMWAC, 1996, p.4). This is equal to the forecast rate of population growth adjusted

for ageing effects, but significantly less than the historical annual rate of growth in Medicare urological procedures of 9.5 per cent. (It is suggested that the rate of growth in Medicare procedures provided principally by urologists was only 1.6 per cent per annum. But unless those procedures account for the entire workload of urologists then some weight must also be put on the higher historical rate of growth.) Hence, there is reason to think that the recommended additional training positions would not be sufficient to meet demand growth. On the supply-side, however, it must be noted that increases in training positions in urology that have been achieved since the AMWAC report are consistent with AMWAC recommendations (AMWAC, 2001b, p.11).

b. General/Vascular Surgery

Evidence on the general surgery workforce in the 1997 AMWAC report suggests several reasons for concern that there may have been a shortage at that time. On the criteria of a minimum health status requirement it seems important to note that 14.3% of the workforce was working more than 70 hours per week (excluding time on call) (AMWAC, 1997a, p.25); and the surgeon/population ratio at the time of the report was below that suggested to be 'desirable' by the Baume report by a very large margin (see Table 5). However, it is concluded that urgent patients are being treated within reasonable time (AMWAC, 1997a, p.45 – see also 1997, pp.27-28), and the urban/rural distribution of general surgery services seems reasonably balanced (AMWAC, 1998, p.64). On the criteria of whether supply meets current demand, one notable indicator is that the average number of Medicare services per provider increased by 9% between 1990-91 and 1995-96. (Over that period the total number of providers of general surgery services increased by 3%, but total services grew by 14.1% - AMWAC, 1997b, p.28.) This would be consistent with a tendency to shortage over that time period.

There is only limited evidence that can be used to make a judgement on the adequacy of the vascular surgery workforce at the time of the AMWAC report (1997). On the criteria of whether supply meets current demand, the average number of Medicare services per provider increased by 11% between 1990-91 and 1995-96. (Over that period the total number of providers of general surgery services increased by 20.2%, but total services grew by 33.9% - AMWAC, 1997b, p.28.) This might be taken to suggest a tendency to shortage over that time period.

There also appear to be grounds for concluding that the general/vascular surgery workforce would have tended to shortage in the period since the AMWAC report. This is on the basis that the assumed rate of growth in demand for general/vascular surgery services seems too low. Whereas the rate of population growth adjusted for ageing effects is forecast to be 1.6 per cent per annum, and historical data on usage of Medicare general and vascular surgery services shows growth of 2.8 and 6.7 per cent (respectively) per annum, the assumed annual rate of growth for making recommendations on training positions is only 1 per cent (AMWAC, 1997a, p.54). However, it must also be taken into account that over the period since the AMWAC review there has been an increase in training positions for general surgery significantly greater than recommended. It was recommended that by 2000 there should be 40 new training positions, but in fact, by 2001 72 new positions had been created.

Quantitative analysis of the effects of alternative assumptions on demand growth and numbers of new graduates is presented in Table 7. It is shown that – where the annual rate of growth in demand is assumed to be 1.6%, and account is taken of the additional new trainees, there would be a current shortage in 2002 of about 6%, but by 2007 the shortage would be largely removed; however, where the annual rate of growth in demand is 2.8%, the current

shortage is about 13%, increasing to about 17% in 2007. It must also be noted that this analysis assumes that the current level of training positions (248) will be maintained. Since it would be most surprising if demand growth did not occur at least at a rate equal to population growth (plus ageing effects), and there must be some doubt that the current level of training positions will continue (since 32 positions are funded under a special rural surgery training program), therefore it seems reasonable to conclude that there is currently a shortage of general surgeons, and that there is also a significant possibility that the shortage will continue over the next several years.

c. Ear, Nose, Throat surgery

There are several indicators that there was a shortage in the ENT workforce at the time of the AMWAC report (1997). On the criteria of achieving minimum health status outcomes the waiting list indicator is consistent with this conclusion – clearance times, the proportion of urgent patients overdue for surgery, and waiting list length for consultation for ENT are all above the average for other specialist surgery areas. Moreover, the surgeon/population ratio at the time of the most recent AMWAC report is below the 'desirable' ratio proposed in the Baume report by a reasonably large margin (see Table 5). On the criteria of whether current supply meets current demand, evidence is available on two relevant indicators – first, there was not growth in the number of ENT surgeons in the three years prior to the report, and only slow growth (at less than rate of population growth) over the preceding twelve years (AMWAC, 1997b, p.4); and second, between 1990-91 and 1995-96 there was substantial growth in Medicare ENT surgery services per provider (5.3% or 12.6% excluding consultations – AMWAC, 1997b, p.29). Together these two indicators suggest a tendency to shortage in the ENT surgery workforce in the time period preceding the AMWAC report. (It is suggested that the growth in services per provider is due to productivity improvements. On the basis of existing evidence, some role for productivity improvements cannot be ruled out. However, the other indicators suggest that under-supply is also likely to be have been a significant factor.)

It also seems reasonable to conclude that there would have been a tendency to shortage in the ENT workforce in the time period since the AMWAC report (1997). First, the assumed rate of growth in demand for ENT surgery services that is used to estimate required training positions is 1.2%. This is equal to forecast population growth, but less than historical growth in hospital separations and Medicare ENT surgery services (see Table 6). The AMWAC report (1997b, p.52) acknowledges that "...this is a conservative estimate of expected future growth". Second, the increase in training positions has been much lower than recommended by AMWAC. In its report AMWAC recommended that there should be 60 training positions in ENT surgery by 2000, but by 2001 there were only 46 training positions (AMWAC, 2001b, p.11). Quantitative analysis (see Table 8) reveals that if the annual rate of growth in demand from 1996 onwards was to be 2.2%, and there is no increase from the current number of trainees, the estimated shortage in the ENT market is extremely large - about 18% in 2002, and reaches almost 29% by 2007.

d. Orthopaedic surgery

There is limited evidence for making a judgement on adequacy of supply of specialist orthopaedic surgeons at the time of the 1999 AMWAC report. On the criteria of minimum health standards one issue of concern is that clearance times for urgent category patients are above average compared to a range of other specialty areas, although waiting time prior to surgery for orthopaedic patients is slightly below average. While perhaps not of such concern for making an assessment on minimum health standards, it is also worth noting that

waiting times and clearance times for non-urgent orthopaedic patients are above the average for a range of speciality areas by a very large margin (AMWAC, 1999, pp.27-28). The surgeon/population at the time of the most recent AMWAC report is below the ratio specified as 'desirable' in the Baume report, albeit by a small margin. Other available evidence that appears relevant to assessment of adequacy of supply is that there had been no change in hours of work of orthopaedic surgeons since the mid-1990s, but that average procedures per surgeon increased by about 2% between 1994-95 and 1996-97 (AMWAC, 1999, p.20 and pp.26-27).

There are relatively strong grounds for thinking that the orthopaedic surgery workforce would be tending to shortage in the time period since the AMWAC report. The assumed rate of growth in demand for orthopaedic surgery services that is used to estimate required training positions is 2.7%. This is above the forecast rate of population growth, and historical growth in hospital separations for orthopaedic procedures; but less than historical growth in Medicare orthopaedic surgery services (see Table 6). On balance, the assumed rate of growth in demand seems slightly low. More important, though, is that intakes of new trainees in orthopaedic surgery have been less than recommended by AMWAC. For example, the recommended intake in 2001 was for 40 first year trainees, but the actual intake was only 36 (AMWAC, 2001b, p.12). Assuming that the training intake remains at the current level of 36 through till 2005, then by 2009 there would be a substantial orthopaedic workforce shortage of 7.5%. (This is estimated as the effect of having 38 less orthopaedic surgeons in 2009 than is forecast in the 1999 AMWAC report. At 56.66 hours per week per surgeon, this would reduce weekly labour supply by 2,153 hours.)

e. Neurosurgery

There is little evidence on which to base a judgement about adequacy of workforce supply at the time of the AMWAC report (2000). One indicator that may be of concern – from the perspective of minimum health standards – is that 33.6% of neurosurgeons are working more than 65 hours per week (and 16% are working more than 80 hours per week) which is above the 28.1% of all surgeons who work above those hours (AMWAC, 2000b, p.20). Another relevant indicator, highlighted in the report, is that waiting times in the public hospital system for patients with urgent conditions are relatively lengthy (AMWAC, 2000b, p.38). The surgeon/population ratio at the time of the most recent AMWAC report was below the ratio specified as 'desirable' in the Baume report, but by a fairly small margin.

There does not appear to be a basis for concluding that the neurosurgery workforce would be tending to shortage or surplus in the time period since the AMWAC report. The assumed rate of growth in demand for neurosurgery services that is used to estimate required training positions is 1.55% per annum. This is consistent with forecast population growth (plus ageing effects), and historical growth in hospital separations for neurosurgery procedures; but below historical growth in Medicare neurosurgery procedures. So the assumed rate of growth in demand for neurosurgery services may be a slight under-estimate of future demand growth. However, whereas the AMWAC report recommended an intake to neurosurgery training of 6 to 8 in each year, in 2001 there was an intake of 13. Hence, any slight under-estimate of demand growth is likely to be off-set by the higher than recommended growth in supply.

f. Cardiothoracic surgery

In making an assessment of adequacy of the cardiothoracic surgery workforce – in terms of the criteria of achieving minimum health status outcomes – a significant issue of concern is hours of work. More than 40% of cardiothoracic surgeons work greater than 65 hours per

week, and over 17% work more than 80 hours per week – On this issue the AMWAC report (2001a, p.38) concluded that "...on balance, the Working Party felt that hours to the stated levels are not necessarily required to ensure a high quality outcome for patients". A further concern is that the surgeon/population ratio at the time of the AMWAC report was below that suggested as 'desirable' in the Baume report by a reasonable large margin. Other evidence however suggests that there does not appear to be a tendency to shortage or surplus in the cardiothoracic surgery workforce in the time period prior to the AMWAC report – the Surgeon/Population ratio is shown to have decreased between 1993 and 1998, and Medicare services per provider were relatively steady between 1995-96 and 1999-2000 (AMWAC, 2001a, pp.22, 33).

On current trends it is not possible to conclude that there is likely to be a tendency to shortage or surplus of cardiothoracic surgeons in future years. The assumed rate of growth in demand for cardiothoracic surgery services that is used to estimate required training positions is 1.8% per annum. This is equal to historical growth in hospital separations for cardiothoracic procedures, above the forecast rate of population growth (plus ageing effects), but below historical growth in Medicare cardiothoracic surgery services (see Table 6). Hence the assumed rate of growth would be at most a slight under-estimate of future growth in demand. Furthermore, for 2001 the first-year intake to cardiothoracic surgery training was 6, compared to a recommended intake by AMWAC (2001b, p.10) of 5 trainees.

h. Summary

The review of specialist surgical workforce adequacy undertaken in this report suggests that – against the criteria of whether workforce size is sufficient to provide minimum acceptable standards of health care and to meet current demand - at present in Australia those workforces fall into three main categories –

1. Strong likelihood of current shortage: Urology, ENT surgery.

Urology: Available indicators at the time of the AMWAC report (1996) – a surgeon/population ratio significantly below the Baume report 'desirable' benchmark; relatively high public hospital vacancy rate; and higher waiting times and clearance times for urgent patients than any other specialty area – provide fairly strong and consistent evidence of a workforce size that was inadequate to meet minimum acceptable healthcare levels. The low assumed rate of growth in demand for services of urologists on which recommendations for numbers of training positions in the subsequent period were based also raises a significant possibility of a tendency to shortage in the period since the AMWAC report.

ENT surgery: Available indicators at the time of the AMWAC report (1997) – a surgeon/population ratio significantly below the Baume report 'desirable' benchmark; waiting times and clearance times for urgent patients that are above-average compared to other specialty areas; and the slow rate of growth in workforce size (relative to service usage and population size) – suggest a strong likelihood of a workforce size that was inadequate to meet minimum acceptable healthcare levels and to meet current demand. The low assumed rate of growth in demand for services of ENT surgeons, and that the increase in ENT surgery training positions has been much lower than recommended by AMWAC, also make it highly likely that a shortage of ENT surgeons would have developed in the period since the AMWAC report. (That shortage is estimated to be as much as 18% in 2002).

2. Likelihood of shortage: General/vascular surgery; Orthopaedic surgery.

General/vascular surgery: Available indicators at the time of the AMWAC report (1997)

provide mixed evidence on the adequacy of supply. On the one hand, the surgeon/population ratio is significantly below the 'desirable' ratio suggested by the Baume report; there appears to have been fairly high growth in services per provider in the time period prior to the AMWAC report; and a quite large fraction of the workforce are working more than 70 hours per week. But on the other hand, waiting times and clearance times seem reasonable, and there does not seem to be a major geographic imbalance. There do however appear to be relatively strong grounds for concluding that a shortage of general and vascular surgeons is likely to have developed in the period since the AMWAC report. The assumed rate of growth in demand for general/vascular surgery services is very low compared to historical growth (and below forecast population growth) so that - even taking account of the growth in training positions above the rate recommended by AMWAC – there is estimated to be a current shortage in 2002 of between 6% and 13%.

Orthopaedic surgery: Available indicators at the time of the AMWAC report (1999) provide only limited and mixed evidence on the adequacy of supply. The surgeon/population ratio is below the 'desirable' ratio suggested by the Baume report; and clearance times for urgent and non-urgent patients are above average. But growth in services per surgeon in the period preceding the report had been fairly small, and there had been no change in hours of work. But there are fairly strong grounds for concluding that a shortage is likely to have developed in the period since the AMWAC report. The assumed rate of growth in demand for orthopaedic surgery services is relatively low, and the actual intake of orthopaedic trainees has been below levels recommended by AMWAC. Only taking account of the effect of the shortfall in trainees it is estimated that there would be between 3.4% and 7.5% shortage in the orthopaedic surgery workforce by 2009.

3. Marginal likelihood of shortage/Limited evidence to make assessment: Neurosurgery; Cardiothoracic surgery.

Neurosurgery: Available indicators at the time of the AMWAC report (2000) provide only limited evidence on adequacy. One issue of concern – from the perspective of provision of minimum acceptable levels of healthcare - is that about one-third of neurosurgeons work more than 65 hours per week. Analysis of AMWAC workforce planning and its recommendations on future training positions suggests that there does not at present seem to be any basis for concluding that a shortage or surplus in the neurosurgery workforce will develop in the near future.

Cardiothoracic surgery: Available indicators at the time of the AMWAC report (2001) on balance provide some evidence of workforce that is inadequate to meet minimum acceptable healthcare levels – the surgeon/population ratio is significantly below the ratio suggested as 'desirable' by the Baume report; and working hours are very long with over 40% of cardiothoracic surgeons working more than 65 hours per week. But other indicators – on the relation between current supply and current demand – do not suggest a shortage. Moreover, analysis of AMWAC workforce planning and its recommendations on future training positions suggests that there does not at present seem to be any basis for concluding that a shortage or surplus in the cardiothoracic surgery workforce will develop in the near future.

Discussion

The three categories of likelihood of workforce shortage have been chosen to distinguish different degrees of confidence that it seems should be attached to the probability of workforce shortage. The judgement on which category is appropriate for a specific workforce reflects two main considerations – first, the number of indicators that are available to assess workforce adequacy for that specific workforce; and second, the type of evidence from the available set of indicators. Other things equal, more confidence is attached to the likelihood of shortage the larger the number of available indicators and the more strongly that those indicators suggest a shortage (for example, where all available indicators suggest that workforce size is not adequate to meet minimum acceptable health levels).

In interpreting the conclusions on the adequacy of the specialist surgical workforces one important point to note is that the degree of likelihood of a workforce shortage for a specific surgical workforce should not necessarily be taken as a signal of the public policy importance of alleviating that shortage. To illustrate this point, suppose that an empirical study finds that there is a strong likelihood that there is a shortage of academic economists, and a marginal likelihood that a shortage of GPs exists. This does not necessarily mean that we should be more concerned – from a public benefit or social welfare perspective – about the market for academic economists than the market for GPs. To the extent that a shortage of GPs imposes much greater losses on society than a shortage of academic economists, then it is possible that we would be more concerned to add extra GPs than academic economists to the labour market. Similarly, the conclusion in this report, for example, that there is a strong likelihood of a shortage of ENT surgeons, and only a marginal likelihood of a shortage of cardiothoracic surgeons, does not necessarily mean that a policy maker should be more concerned about the ENT surgeon market than the cardiothoracic surgeon market. If it is believed that the social losses from a shortage of cardiothoracic surgeons are much greater than social losses from a shortage of ENT surgeons, then even the finding that there is a marginal likelihood of a shortage of cardiothoracic surgeons may mean it is appropriate to concentrate extra resources on rectifying any potential shortage in that market before attempting to rectify the shortage in the ENT surgical workforce.

i. Comparison with AMWAC reports

In its individual reviews of specialist surgery workforces (AMWAC, 1996, 1997a, 1997b, 1999, 2000b, 2001a) AMWAC concluded that supply in each workforce was adequate. In its Annual Report for 2000-2001 AMWAC states (2001b, p.7) nominates urology, ENT surgery, and orthopaedic surgery as areas "...likely to experience shortages if not corrected".

The conclusions of this report can be seen as consistent with the AMWAC 2000-2001 Annual Report in that urology, and ENT surgery are identified as specialist surgical areas where there should be most concern about workforce shortage. In other words, the relative ranking that this report and the AMWAC Annual Report attach to the likelihood of shortage in each specialist surgical area seems quite similar. Where this report and the AMWAC reviews and Annual Report differ however is in their conclusions about 'levels'. Whereas this report concludes that it is at least likely that there are current shortages in five of the seven specialist surgical workforce areas examined, the AMWAC reports have concluded that no shortage currently exists in any area. The explanation for the difference in conclusions is probably twofold – first, this report and the AMWAC reports take somewhat different approaches to interpretation of available indicators of workforce adequacy; and second, this report has the advantage of being able to evaluate likely trends in demand, and actual changes in supply,

that have occurred in the time period after each AMWAC report.

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Table 1: Surgeons by main speciality of practice – 1998

	Number	Percent
General surgery	1028	35.0
Cardiothoracic surgery	97	3.3
Neurosurgery	102	3.5
Orthopaedic surgery	714	24.3
Ear, nose, throat	302	10.2
Paediatric surgery	77	2.6
Plastic surgery	256	8.7
Urology	222	7.6
Vascular surgery	140	4.8

Source: Australian Institute of Health and Welfare, Medical Labour Force 1998, accessed at http://www.aihw.gov.au/publications/health/mlf98.

Table 2: Medicare providers by speciality area, 1991-92 to 1998-99

	Surgeons - Total	Surgeons - Specialist	Surgeons – Non-specialist	Surgeons/Total Medicare providers
1991-92	4140	3355	785 (19.0)	18.2
1992-93	4270	3433	837	18.5
1993-94	4418	3479	939	18.7
1994-95	4597	3586	1011	19.0
1995-96	4714	3598	1116	19.3
1996-97	4816	3641	1175	19.6
1997-98	4898	3703	1195	20.2
1998-99	5049	3844	1205 (23.8)	20.9

Source: Australian Institute of Health and Welfare, Medical Labour Force 1998, accessed at http://www.aihw.gov.au/publications/health/mlf98.

Table 3: Number of surgeons/providers of surgical services

	AIHW – Specialty of main practice	Society/association membership	Medicare
Urologists (1996)		200	227
ENT surgeons (1995-1997)	315	271	317
General surgeons (1995-1996)	1135	1072	1186
Orthopaedic surgeons (1997)	689	696	660
Neurosurgeons (1997-2000)	113	104	108
Cardiothoracic surgeons (1999-2000)	97	104	103

Source: AMWAC (1996, 1997a, 1997b, 1999, 2000b, 2001a).

Table 4: Average number of Medicare services per capita, 1990-91 to 1998-99

	Specialist attendances	Operations	Total services
1990-91	0.86	0.26	4.91
1991-92	0.89	0.27	5.08
1992-93	0.92	0.28	5.27
1993-94	0.94	0.28	5.41
1994-95	0.97	0.28	5.45
1995-96	0.99	0.29	5.58
1996-97	0.98	0.29	5.53
1997-98	0.97	0.29	5.50
1998-99	0.98	0.29	5.40

Source: Australian Institute of Health and Welfare, Medical Labour Force 1998, accessed at http://www.aihw.gov.au/publications/health/mlf98.

Table 5: Surgeon/Population ratios – Desirable and actual, Australia

	Desirable	**Actual**	**Ratio – Desirable/Actual**
Urology	1:60,000	1:90,119 (1996)	0.67
General surgery	1:11,000	1:14,930 (1996)	0.74
ENT surgery	1:50,000	1:58,000 (1997)	0.86
Orthopaedic surgery	1:25,000	1:26,240 (1998)	0.95
Neurosurgery	1:175,000	1:183,763 (2000)	0.95
Cardiothoracic surgery	1:150,000	1:180,347 (1998)	0.83

Note: Desirable ratios are from Baume (1994, pp.55, 57, 59, 60, 67, and 69). The ratios are generally those that were specified by RACS or the respective specialist surgical association/society. Actual ratios are from AWMAC (1996, p.3; 1997a, p.16; 1997b, p.5; 1999, p.10; 2000b, p.33; and 2001a, p.33).

Table 6: Data and assumptions on annual rate of growth of service usage – AMWAC Working Party reports

	Population growth (+Ageing effects)	**Hospital separations**	**Medicare items**	**Assumed future rate of growth**
Urology	1.6		9.5	1.6
General surgery	1.6		2.8	1.0
Vascular surgery	1.6		6.7	1.0
ENT surgery	1.2	2.8	2.2	1.2
Orthopaedic surgery	1.2	2.3	8.0	2.7
Neurosurgery	1.5	1.6	6.0	1.55
Cardiothoracic surgery	1.3	1.8	2.2	1.8

Source: AMWAC (1996; 1997a – Table 43 and p.54; 1997b – pp.32, 52; 1999 – Table 21 and pp.29-30; 2000b – pp.40, 46-47; 2001a – pp.44-45, 55).

Note: Measures of rates of growth in hospital separations and Medicare items cited have been chosen – to the extent possible - to be representative of the range of data on growth in total services/procedures for each specialist surgical workforce.

Table 7: Supply of and demand for general surgery services

	(1)	(2)	(3)	(4)	(5)	(6)
	Demand-1.6%	**Demand-2.8%**	**Supply(base)**	**Supply(extra)**	**%shortage(1.6)**	**%shortage(2.8)**
1996	64856	64856	65241	65241	-0.59	-0.59
1997	65893.7	66671.97	64856	64856	1.60	2.80
1998	66948	68538.78	64963	64963	3.05	5.50
1999	68019.16	70457.87	65312	65312	4.14	7.87
2000	69107.47	72430.69	65750	65750	5.10	10.16
2001	70213.19	74458.75	66194	66194	6.07	12.48
2002	71336.6	76543.59	67185	67335	5.94	13.67
2003	72477.99	78686.81	68130	68580	5.68	14.73
2004	73637.63	80890.05	69029	69029	6.67	17.18
2005	74815.84	83154.97	69892	71692	4.35	15.98
2006	76012.89	85483.31	70734	73434	3.51	16.40
2007	77229.1	87876.84	71568	75168	2.74	16.90

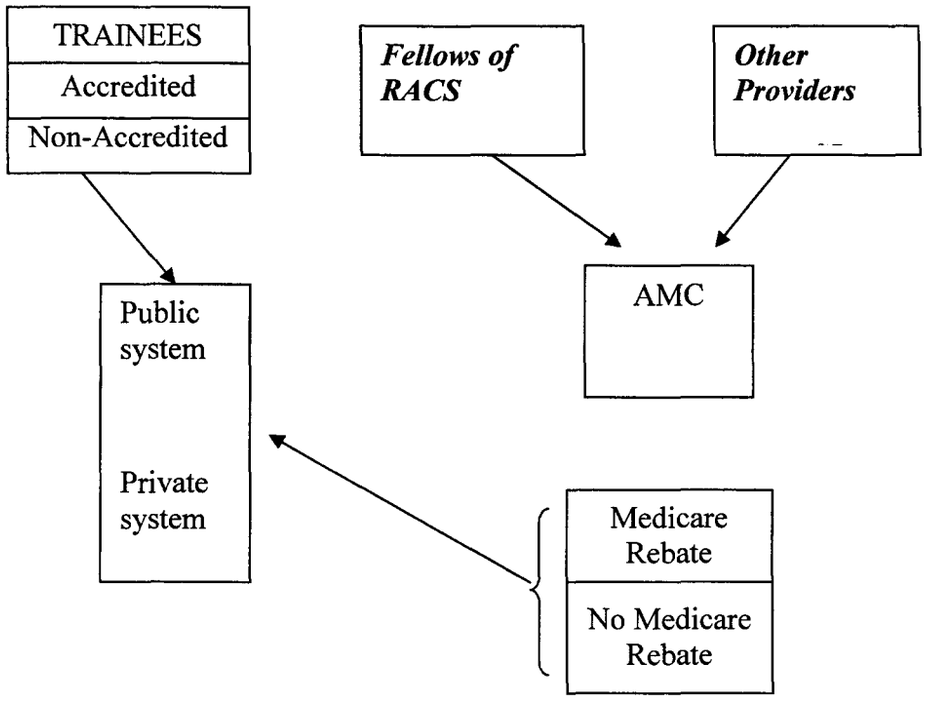
Note: Columns (1) and (2) show projected weekly hourly requirements based on assumptions of (respectively) 1.6% and 2.8% annual rates of growth. Column (3) shows projected weekly hours of labour supply based on recommended training positions (AMWAC, 1997a, Table 46). Column (4) shows projected weekly hours of labour supply based on actual training positions. Instead of 52 graduates in each year from 2001 to 2007 it is assumed that new graduates are: 2001 – 52; 2002 – 54.5; 2003 – 57; 2004 – 59.5; 2005 – 62; 2006 – 62; 2007 – 62. It is also assumed that each extra new graduate will add 60 hours per week to total labour supply. It is assumed that no retirements would have occurred from new general surgeons who enter the workforce between 2001 and 2007.

Table 8: Supply and demand for ENT surgery services

	(1)	(2)	(3)	(4)
	Demand - 2.2%	Supply(base)	Supply(extra)	%shortage
1996	16005.93			
1997	16198	16012	16012	1.161629
1998	16554.36	15680	15680	5.57625
1999	16918.55	15561	15561	8.724065
2000	17290.76	15460	15460	11.84191
2001	17671.16	15532	15532	13.77258
2002	18059.92	15450	15275	18.2319
2003	18457.24	15693	15343	20.29747
2004	18863.3	15936	15411	22.40153
2005	19278.29	16180	15480	24.53677
2006	19702.41	16424	15549	26.71178
2007	20135.87	16670	15665	28.54049

Note: Column (1) shows projected weekly hourly requirements based on assumed annual rate of growth of 2.2%. Column (2) shows projected weekly hours of labour supply based on recommended training positions (AMWAC, 1997b, Table 39). Column (4) shows projected weekly hours of labour supply based on actual training positions. Instead of 15 graduates in each year from 2002 to 2007 it is assumed that new graduates are: 2002 – 11.5; 2003 – 11.5; 2004 – 11.5; 2005 – 11.5; 2006 – 11.5; 2007 – 11.5. It is also assumed that each extra new graduate will add 50 hours per week to total labour supply. It is assumed that no retirements would have occurred from new ENT surgeons who enter the workforce between 2002 and 2007.

Figure 1: Supply of Specialist Surgical Services



ATTACHMENT D

TERMS OF REFERENCE FOR REVIEW OF CRITERIA FOR ACCREDITING HOSPITAL TRAINING POSTS FOR ADVANCED SURGICAL TRAINING AND HOSPITALS FOR BASIC SURGICAL TRAINING

Review committee

The review shall be conducted by a committee consisting of:

- one or more persons nominated by the Royal Australasian College of Surgeons (the College);
- one or more persons nominated by the Australian Medical Council (the AMC); and
- one or more persons nominated by the Australian Health Ministers Conference (the AHMC) or its delegate.

The number of persons comprising the committee shall be jointly determined by the three organisations. Each organisation shall have equal representation.

The Commission suggests that the AHMC (or delegate) should consider appointing a person from a rural and regional area.

The size and structure of any secretariat shall be determined by the agreement of the organisations. The head of the secretariat shall be jointly appointed by the College and the AHMC (or its delegate).

Review principles

The review committee shall review the College's criteria for accrediting hospital posts for advanced surgical training and its criteria for accrediting hospitals for basic surgical training taking into account the following principles:

- the criteria should be such as to ensure that, upon completing their training (including relevant examinations) surgeons are safe and competent;
- except where specifically Australian conditions need to be addressed, the criteria should be broadly consistent with those existing in comparable countries;
- subject to the principles above, the criteria should facilitate training in the widest range of hospitals possible, and particularly in hospitals in outer-metropolitan, rural and regional areas;
- the criteria should be as objective as practicable and appropriate subject to the above principles;
- the criteria should be expressed in as reader-friendly a manner as possible;
- criteria should be publicly justified; and
- if some criteria are inherently more important than others, this should be explicitly recognised.

The review should also examine whether it is feasible to:

- accredit hospitals rather than hospital posts for advanced surgical training; and
- recognise retrospectively work undertaken in non-accredited training positions for the purpose of completing advanced surgical training.

Review process

As soon as practicable after the review commences, the review committee shall seek written submissions from parties that have an interest in the matter. These parties shall include Commonwealth, state and territory health ministers, the AMC, the College and key consumers groups (for example, the Australian Consumers Association and the Consumers Health Forum of Australia). The committee shall allow interested parties a reasonable time to lodge submissions.

The review committee shall prepare a draft report, taking into account submissions from interested parties, containing:

- its assessment of the extent to which the criteria for accrediting hospitals for basic surgical training and the criteria for accrediting hospital posts for advanced surgical training are consistent with the review principles;
- revised criteria as appropriate in light of this assessment;
- if necessary, a mechanism for ranking the importance of individual criteria or groups of criteria;
- the justification for each criterion in each set of criteria; and
- an indication of how the issues raised in submissions have been addressed with a view to adoption or otherwise.

The draft report should also contain the committee's draft assessment of whether it is feasible to:

- accredit hospitals rather than hospital posts for advanced surgical training; and
- recognise retrospectively work undertaken in non-accredited training positions for the purpose of completing advanced surgical training.

This draft report shall be provided to all interested parties, who shall be invited to lodge written submissions in response to it within a reasonable time. The review committee shall take account of submissions in response to its draft report.

A draft final report shall be provided to the College for comment within a reasonable time period solely on implementation issues. The AHMC shall also be provided with a copy.

The review committee shall then issue a final report to all interested parties.

The committee may meet with interested parties during the review as the need arises.

Review timetable

The College shall write to the AHMC (or its delegate) and the AMC seeking nominations to the review committee within one month of the authorisation commencing. Copies of the

letters shall be provided to the Commission at the time they are sent. The College shall inform the Commission of the composition of the review committee when it is finalised and when the review will commence. The review shall commence as soon as practicable after the review committee is finalised and other matters requiring the agreement the AHMC (or its delegate) are settled. The review committee should issue a final report within nine months of its commencement. The committee may write to the Commission seeking an extension of time, which the Commission may grant.

Costs

The College shall bear all costs associated with the review unless health ministers agree to make a contribution. The Commission considers that health ministers should contribute half the costs of the review.

Confidentiality

Given the technical nature of the review, all submissions (including minutes of meetings) to the review committee should ideally be publicly available. However, the review committee may grant confidentiality to submissions in accordance with the following principles:

- where a party making a submission requests confidentiality, the review committee should first consider whether there is any compelling reason why the content of the submission could not be publicly disclosed in a manner which does not identify the party making the submission; and

- if this is not possible or is otherwise inappropriate, it may consider granting confidentiality to the body of a submission in full or in part (as well as the identity of the submitting party).

The review committee and secretariat should execute such confidentiality agreements as are agreed by the College and the AHMC (or its delegate).

Implementation of review findings

The College shall implement the findings of the review within three months of the release of the final report except where the College obtains the agreement of the majority of the AHMC that a review committee recommendation should not be adopted. The three month period for implementing the review committee recommendations shall not include the time between when (if this occurs) the College writes to health ministers proposing that a review recommendation not be adopted and when it receives all replies from the AHMC.

Commission role

The Commission will not participate in the review. However, the review committee shall provide the Commission with copies of its draft, draft final and final reports. The review committee shall also, if requested, provide the Commission with copies of any public submissions to the review, in the form that they are publicly available, including minutes of meetings with interested parties.

ATTACHMENT E

TERMS OF REFERENCE FOR REVIEW OF ASSESSMENT OF OVERSEAS-TRAINED SURGEONS

Review committee

The review shall be undertaken by a committee consisting of:

- one or more persons nominated by the Royal Australasian College of Surgeons (the College);
- one or more persons nominated by the Australian Medical Council (the AMC); and
- one or more persons nominated by the Australian Health Ministers Conference (the AHMC) or its delegate.

The number of persons comprising the committee shall be jointly determined by the three relevant bodies. Each body shall have equal representation.

The Commission suggests that the AHMC (or delegate) should consider appointing a person from a rural and regional area.

The size and structure of any secretariat shall be determined by the agreement of the organisations. The head of the secretariat shall be jointly appointed by the College and the AHMC (or its delegate).

The test for assessing overseas-trained medical specialists

The review committee should examine whether equivalence, substantial comparability, competence or another test is the preferable test for assessing overseas trained surgeons. It should examine these issues for each of the following categories:

- overseas trained surgeons who are seeking full registration to practise as a specialist in Australia;
- overseas trained surgeons who are seeking conditional registration to practise within a limited area of specialisation or subspecialty practice; and
- overseas trained surgeons who are seeking registration to practise in an area of need, and whose practice is limited by conditional registration to a specific role that is determined by the job description for the position.

In particular, the review committee will examine for each potential test;

- the characteristics of an overseas-trained surgeon that would be examined for each test (for example, work experience, training and academic qualifications);
- the factors that would be relevant to assessing these characteristics – for example, the factors relevant to assessing the quality of an overseas-trained surgeon's qualifications, training or work experience;
- the justification for these factors. If some factors are inherently more important than

others, this should be explicitly recognised.

The overall aim of the review is to identify the minimum requirements that overseas-trained surgeons need to meet before they should be permitted to practise in Australia.

The review committee will also examine:

- whether persons who have completed particular overseas training programs could be automatically exempted from being required to undertake basic and/or advanced surgical training. The committee need not consider qualifications awarded in countries from which, based on previous experience, an insignificant number of candidates are likely to originate in the future; and

- if such programs are found to exist, what if any requirements it would be appropriate to impose to enable an assessment of the relevant surgeons' abilities in practice.

The review committee will also examine, for overseas-trained surgeons assessed by the College as requiring additional training short of completing the College's training program in full, what processes could be established to ensure that this limited training is available.

Process

As soon as practicable after the review commences, the review committee shall seek written submissions from parties that have an interest in the matter. These parties shall include Commonwealth, state and territory health ministers, the AMC, the College, National Office of Overseas Skills Recognition and key consumers groups (for example, the Australian Consumers Association and the Consumers Health Forum of Australia). The committee shall allow interested parties a reasonable time to lodge submissions.

The review committee shall prepare a draft report, taking into account submissions from interested parties.

This draft report shall be provided to all interested parties, who shall be invited to lodge written submissions in response to it within a reasonable time. The review committee shall take account of submissions in response to its draft report and in particular, any concerns raised regarding implementation of any of its draft recommendations.

A draft final report shall be provided to the College for comment solely on implementation issues within a reasonable time. The AHMC shall also be provided with a copy.

The review committee shall then issue a final report to all interested parties.

The committee may meet with interested parties during the review as the need arises.

Review timetable

The College shall write to the AHMC (or its delegate) and the AMC seeking nominations to the review committee within one month of the authorisation commencing. Copies of the letters shall be provided to the Commission at the time they are sent. The College shall inform the Commission of the composition of the review committee when it is finalised and when the review will commence. The review shall commence as soon as practicable after the review committee is finalised and other matters requiring the agreement the AHMC (or its delegate) are settled. The review committee should issue a final report within nine months of

its commencement. The committee may write to the Commission seeking an extension of time, which the Commission may grant.

Costs

The College shall bear all costs associated with the review unless health ministers agree to make a contribution. The Commission considers that health ministers should contribute half the costs of the review.

Confidentiality

All submissions (including minutes of meetings) to the review committee should ideally be publicly available. However, the review committee may grant confidentiality to submissions in accordance with the following principles:

- where a party making a submission requests confidentiality, the review committee should first consider whether there is any compelling reason why the content of the submission could not be publicly disclosed in a manner which does not identify the party making the submission; and

- if this is not possible or is otherwise inappropriate, it may consider granting confidentiality to the body of a submission in full or in part (as well as the identity of the submitting party).

The review committee and secretariat should execute such confidentiality agreements as are agreed by the College and the AHMC (or its delegate).

College to prepare guidelines

Within three months of the review finishing, the College shall:

- prepare and publish on its website interim guidelines that incorporate and are consistent with the findings of the review committee as regards the way that the equivalence test is to be administered;

  - except where the College obtains the agreement of the majority of the AHMC that a review committee finding should not be adopted.

The guidelines should also include an outline of the assessment process, including fees, timeframes, the Council's role and other related matters.

Ultimately, the guidelines should provide the public, including overseas-trained surgeons, with a framework for assessing whether decisions made in relation to particular overseas-trained surgeons are reasonable.

If the AHMC ultimately decides to change the test for evaluating overseas-trained surgeons, the College shall, within three months of the AHMC decision:

- prepare and publish on its website guidelines that incorporate and are consistent with the findings of the review committee as regards the way that the test approved by AHMC is to be administered (or the findings of the review that are most applicable to the test approved by the AHMC);

  - except where the College obtains the agreement of the majority of the AHMC that

a review committee finding should not be adopted.

Commission role

The Commission will not participate in the review. However, the review committee shall provide the Commission with copies of its draft, draft final and final reports. The review committee shall also, if requested, provide the Commission with copies of any public submissions to the review, in the form that they are publicly available, including minutes of meetings with interested parties.

ATTACHMENT F

SUMMARY OF THE BRENNAN BEST PRACTICE FRAMEWORK FOR TRAINEE SELECTION[1]

- There should be a clear statement of principles that underpin the selection process.
- There should be a clear statement of eligibility to apply for, and be selected for, training.
- There should be a national awareness opportunity for all eligible candidates.
- Quotas, if applicable, and limits relating to other factors, such as the number of training positions should be explicit and openly declared.
- Referee's reports should be pro forma with a view to achieving objectivity, comparability and quantification.
- The Selection Committee should have the confidence of the candidate, the profession and the community. The size of the Committee proportional to the task. Committees should be aware that they may be held accountable for their decisions. The selection process should be valid, reliable and feasible, with evaluation built into the process.
- The selection criteria should be documented and published. To the greatest extent possible they should be objective and quantifiable.
- The interview should be objective and free of bias.
- The selection process should be based on the published criteria and the principles of the college concerned whilst also being capable of standing up to external scrutiny.
- Adequate documentation enables external scrutiny, audit and evaluation of the selection process. It should enable accurate reconstruction of the original detail and process.
- Candidates should be given or at least offered a frank appraisal of their standing in the eyes of those conducting the selection process.
- There should be a formal, regular inclusive review of the process.
- There should be a formal process for reviewing/appealing decisions in relation to selection.

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[1] Dr Peter J Brennan, *Trainee Selection in Australian Medical Colleges*, January 1998.

ATTACHMENT G

The following interested parties lodged public submissions in response to the Commission's draft determination.

Australian Health Ministers Conference (AHMC)
Anti Discrimination Board of New South Wales
Australian Doctors Trained Overseas Association
The University of Sydney
Australian Medical Council
The Royal College of Pathologists of Australasia
Royal Australian College of Obstetricians and Gynaecologists (RANZCOG)
The Royal College of General Practitioners
Catholic Health Australia
Dr Mark Shanahan
Mayne Health
Hunter Area Health Service
Health Care Complaints Commission (NSW)
The University of Queensland
Medibank Private
Health Services Commission (Victoria)
Health Complaints Commissioner (Tasmania)
Australian College of Dermatologists
Medical Industry Association of Australia
Committee of Presidents of Medical Colleges
Australian Consumers' Association
Australian and New Zealand College of Anaesthetists
Health Consumers' Council (WA)
Australian Private Hospitals Association
Medical Board of Western Australia
Community Relations Commission of New South Wales
Western Australian Minister for Health, the Hon Bob Kucera, APM MLA
Australian Medical Association