New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 160

Name: Australian Society of Anaesthetists

Date Received: 4/12/2023

Australian Society of Anaesthetists™

PO Box 76, St Leonards NSW 1590 Australia
t: 1800 806 654 | e: asa@asa.org.au
www.asa.org.au | ABN: 16 095 377 370

November 2023

Australian Society of Anaesthetists Submission

Special Commission of Inquiry into healthcare funding in NSW

Contents

About the Australian Society of Anaesthetists

Established in 1934, the Australian Society of Anaesthetists (ASA) was founded to unite professionals in the field of anaesthesia and advocate on their behalf. Today, the ASA continues to operate as a not-for-profit member-funded organisation dedicated to supporting and connecting Australian anaesthetists. The ASA currently has 4,160 members. Approximately 2,500 of these are practising anaesthetists and over 500 are registered with the Australian and New Zealand College of Anaesthetists (ANZCA) anaesthesia training program.

The ASA has a diverse membership base, representing anaesthetists in metropolitan and regional areas as well as in public, private and blended public/private practice. There are more than 5,800 anaesthetists currently registered in Australia. In addition to playing a vital role in more than 4 million surgical operations every year in Australia, anaesthetists also provide specialised care during medical procedures and in critical care settings. A key focus of the profession is on safety and quality to deliver good health outcomes for the community.

This submission was drafted by the ASA NSW Committee on behalf of the ASA.

It is through the activities of our State Committees that members are actively engaged with the work of the Society. State Committee's play a vital role in actively promoting the Vision and Mission of the Society at a State level.

Vision

Practitioners functioning at their best in the delivery of anaesthetic and peri-operative care.

Mission

Support, represent and educate our members in the provision of high-quality healthcare that ensures patient safety in anaesthesia, peri-operative and pain medicine.

1. Exodus of Staff Specialist Anaesthetists from the Public Hospital System

This part of our Submission is directly relevant to Terms of Reference F:

The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services.

1.1 Overview

The exodus of Staff Specialist anaesthetists from the public hospital system should be of concern to NSW Health. It is driven by several complex factors including:

- **State Government wages policy**. This has driven the industrial bargaining (or more correctly lack thereof) resulting in working conditions, workplace support, workplace morale and pay for Staff Specialists in NSW falling behind every other state in the country.
- **Industrial conditions** have been eroded further even as specialists work harder to look after critically ill patients with fewer and fewer resources, with after-hours complex elective, urgent, and emergency work not being recognised and remunerated appropriately.
- **Inadequate work force planning**. Increasingly, the failure to continually review health care demand and determine public health system operational capacity requirements (infrastructure, resources, staffing subacute discharge capacity, etc.) has resulted in workforce reaching breaking point. The failure of adequate investment in infrastructure and workforce to drive more efficient care in public hospitals, has resulted in NSW Health having to outsource to the private sector. Public outsourcing to the private health sector is choosing short-term fixes over the investment needed to increase NSW Health System Capacity
- The **Federal government funding** of healthcare in NSW under the national reform agreement, the Activity Based Funding Caps, and the complexities around Medicare billing of patients seen and treated in public outpatients create complexities which need to be addressed. These complexities favour some medical craft groups over others. The ASA notes and supports the AMA Clear the Logjam campaign. Federal funding must be increased to 55:45 ratio, to help provide the investment required in the health workforce.
- **Health Bureaucracy Inaction**. The overwhelming frustrations faced by anaesthetists has been the disconnect between the message being delivered by anaesthetists to the health bureaucracy, at all levels including the Ministry, and the response to this message.

Inaction has resulted in the degradation of confidence in the management and direction of healthcare.

The routine experience for Staff Specialists forces them to confront a grim reality every day – NSW Health shows by its inaction that it has no understanding that its greatest asset is the highly skilled and committed clinicians and other healthcare workers who coordinate and deliver the patient care 24/7 every day of the year.

That reality and the exodus of anaesthetists from the public system then translates into a lack of access to elective and emergency surgery for patients across the state. Without the clinicians there is no healthcare system and the training pipeline for specialist anaesthetists is a minimum of 11 years from entry to medical school, or more realistically 12-13 years.

The ASA has an in depth understanding of the impact on anaesthetists of present working conditions. This is in part related to direct feedback from our deeply engaged membership. It is particularly striking that there is a noticeably clear difference in the feedback we receive from anaesthetists in NSW compared to anaesthetists in other states. It does not offer a positive picture of the NSW Health system, and critically, the engagement and relationship that system maintains with its clinicians.

Our understanding is also driven by our support of practitioners in multiple NSW hospitals tackling a recruitment and retention crisis created by conditions that do not compete with other states, such as the Department of Anaesthesia at The Children's Hospital at Westmead.

The corrosive effect of abandoning the Staff Specialist workforce has flow on effects that damage the public health system and threaten the development of a future workforce to look after the community. Traditionally staff Specialists have played a particularly vital role in:

- Clinical governance initiatives that drive system improvement, deliver better health care in the long run and ultimately contain healthcare costs.
- Contribution to world leading research through original research and participation in major multicentre trials and research projects
- Education and training the future health workforce – including anaesthetic and other medical trainees, nursing staff and paramedics that are essential to provide health care for an ageing population with more complex health conditions now, and into the future.
- Senior leadership and hospital wide engagement, because of the integral role that anaesthesia and perioperative care plays throughout the hospital system across all specialty areas.
- Provide the constant presence and engagement essential for the workforce and workplace fabric that enables cohesion, consistency, and integration of health care services being provided.

There is presently no effort to adequately capture the value of these critical roles to the public health system. What is not measured gets forgotten, and unfortunately what has been forgotten has to be relearnt and rebuilt. The system is blind to its best avenues for innovation and more cost-effective healthcare.

A change in direction is required to restore an appropriate balance to the anaesthesia workforce, offering all the advantages of a mix of Staff Specialists and Visiting Medical Officers working on behalf of the community.

The Special Commission represents a tremendous opportunity to change things for the better with a few simple steps:

- Urgently update the NSW Staff Specialist Award to make this employment category a competitive and sustainable employment option for anaesthetists currently in the workforce and those about to enter the workforce.
- Rebuild NSW anaesthesia workforce Full Time Equivalent (FTE) numbers so that acceptable work conditions are met, and the full potential and benefits of engaging Staff Specialists are realised.
- Create flexibility to incentivise clinicians to be Staff Specialists in NSW, with deep engagement in areas of need such as rural and regional areas, which are highly reliant on locum anaesthetists to deliver healthcare. Engagement is needed with the anaesthesia workforce to seek long term sustainable regional and rural workforce solutions.

This is achievable **if** there is a commitment to investment in competitive health system employment reform. It is an approach that offers more for the NSW community with a more efficient approach to delivering health services.

An ongoing approach of leaving NSW languishing behind every other state is a surefire way of delivering ongoing pain for the patients who have a right to expect the best possible care, and the cost to rebuild a system that declines any more will be much greater than doing so now.

1.2 NSW Staff Specialists Award does not reflect the reality of healthcare delivery

Staff Specialists in NSW are employed under an Award that does not reflect the reality of healthcare delivery. This is a problem unique to this state and a significant contributor to the exodus of practitioners from the public system to private practice, to locum anaesthesia work, and interstate to more competitive and attractive conditions. This is particularly the case in anaesthesia.

The present Award was first drafted in 1966. The last substantive review to consider whether the Award was drafted in a matter fit for the nature of the work occurred in 2006 and was

directed at considering the work of Emergency Physicians. Medicine in 2023 is not the same as it was in 2006.

Every other state has recognised the changing nature of medicine through Awards or Agreements that reflect the actual work done and the nature of the workforce. This encourages deep engagement in the system. By making work arrangements appealing, competitive with other states and the private health sector, and recognising onerous out of hours work equitably, they have stabilised the workforce so they can focus on delivery of care, required 24/7 every day of the year.

Other states in Australia:

- Deliver base remuneration for specialists up to 50% higher than the total remuneration to attract and retain clinicians in NSW.
- Recognise out of hours work, whether it is overtime or as part of on-call, recall and digital recall arrangements, with direct pay for the time worked using salary, fee for service, or a combination of both.
- Recognise explicitly the value of clinical support activities (research, governance, education and support of new technology and information technology systems) in driving positive change in healthcare delivery and delivering more efficient healthcare in the long-term.
- Feature specific clauses that show a commitment to the health of senior medical practitioners, such as the specified breaks to manage fatigue (reflected in Queensland's Certified Agreement No. 6, 2022, Clause 5.4).
- Make features to support Training, Education and Study more available to clinicians such as by providing this as a component of routine pay without barriers to access.
- Incentivise additional out of hours work to surge for urgent elective surgery, and short notice surgical procedures which clinically must be undertaken afterhours, on a weekend or public holiday.

1.3 The NSW Health Response – Ignoring Reality

The position of NSW Health and the Secretary of Health is that none of this is relevant. They make the case that Staff Specialists receive a salary that includes an allowance to cover the possibility of working more than the Award's specified 40 hours per week.

However, the complexity of clinical work and the progressive need for anaesthetists to work extended hours looking after critically ill patients or attending at all hours of the day or night has increased massively for more than a decade, and the current provisions do not match the clinical hours worked in 2023.

The Secretary of Health and NSW Health confessed as much by not contesting evidence showing the increasingly onerous nature of delivery of this high intensity care in proceedings at the Industrial Relations Commission in 2022. This evidence was presented by the Australian Salaried Medical Officers Federation (ASMOF) as part of a dispute before Commissioner Sloan (2022/00009840 Australian Salaried Medical Officers' Federation (New South Wales) v Health Secretary in respect of the Sydney Children's Hospitals Network).

This evidence relates to the work of the specialists in anaesthesia and intensive care at The Children's Hospital at Westmead. Evidence in the proceedings records anaesthetists providing up to 24 hours of continuous onsite care for patients, and routinely providing onsite care more than 20 hours in a 24-hour period when 'on call'.

This was reflected on by the Commissioner as 'uncontested evidence that over the last 10 years there has been an increase in the complexity, acuity and number of patients being treated in the Departments' and that he 'cannot readily accept the Health Secretary's submissions … that the "average hours worked by these specialists over the roster period in evidence are not excessive"…'

The realities of the changing nature of anaesthesia care, the challenges it imposes, and the implications for the health system have not just been recognised at the IRC. The ASA wrote to both the Secretary of Health and the former Minister for Health in 2022 to highlight our specific concerns relating to the anaesthetists at The Children's Hospital at Westmead. Public reporting records that the Australian and New Zealand College of Anaesthetists also highlighted this issue with a particular note of concern relating to paediatric perioperative medicine and training of the future workforce of NSW.

The issues faced by anaesthetists at The Children's Hospital at Westmead are not isolated to that institution and are reported in feedback from our members right across the state. The problems with the present approach to this problem have been highlighted by those anaesthetists, reported by both the ASA and ANZCA, and reinforced by the IRC.

The response from NSW Health seems to be a commitment to the status quo.

The work demanded of a Staff Specialist anaesthetist has become more complex with higher acuity of the patients requiring care. There is now an expectation that specialists will accept working extreme hours or spend 'on call' times providing continuous clinical care. The failure to update the Award in a way that justly reflects this highly specialised work in the same manner as other states or the Visiting Medical Officer determination or the private sector, is driving people away from being a Staff Specialist.

The Award is a barrier to delivering a sustainable workforce to support healthcare in NSW. It needs to change.

That is not just the position of the ASA. It is the Commissioner who noted that there was 'considerable support in the evidence for changes to the Award.'

1.4 Feedback from ASA members

The barriers to taking up a Staff Specialist position are very much reflected in a survey of Australian Society of Anaesthetist members undertaken by our organisation in preparation for this submission. In overwhelming numbers, the lack of a just and equitable approach to pay was cited as the barrier to considering a role as a Staff Specialist.

However, the feedback also highlights broader issues. There are issues with the environment and the conditions under which work is demanded of the anaesthesia workforce that is driving skilled clinicians out of the system.

These are clinicians motivated by more than pay, as evidenced by the keenness to adapt, and show flexibility during the peak demands of the COVID-19 pandemic, where specialist anaesthetists were on the frontline leading intubation teams, bolstering our intensive care workforce, and providing a 24-hour on-site consultant presence. There are deeper issues. More is being demanded despite worsening conditions while the attitude of actions of NSW Health and administrators reveal that the value of senior clinicians is not recognised.

A workforce that can see they are not valued are voting with their feet, at a time where there is high demand and highly competitive employment alternatives. Once you lose anaesthetists from highly specialised areas, it can be incredibly difficult to get them back, or to fill the void created by their departure.

Throughout the responses key themes emerge:

a) Base pay does not measure up to the rest of the health landscape whether interstate, or in the private sector.

b) The system relies on specialist anaesthetists working extended hours day-in and day-out with no recognition of that work, with there being no foreseeable changes in the future. No other state does this.

c) The continual expectation to deliver more surgeries with more complex requirements with less resources is leading to significant workplace dissatisfaction, moral injury, and burnout.

d) Understaffing leaving no capacity to perform clinical support activities to sustain a rewarding career (with examples such as research, teaching or training the workforce of the future cited).

e) An imbalance of administrative support at the right level leaving Staff Specialists responsible for basic administration such as rosters and clerical work rather than delivering real system change. An expansion in middle management rather than

administrative support has distorted efficient use of clinicians to deliver healthcare and better outcomes.

f) All relevant leave types in the Staff Specialist Award are denied due to understaffing which removes the intended benefits of work-life balance and long-term engagement with the public health sector. Work entitlements are treated as non-essential.

g) The reliance of NSW Health on elements of the Award that allow salary to be supported by billing of patients that utilise their private health insurance in the public system is increasingly irrelevant to specialist anaesthetists across most of NSW and specifically to those in rural and regional areas.

This feedback was not confined to a specific group of anaesthetists. It is the feedback from ASA members in big city hospitals delivering the most unique and highly specialised care. It is the feedback from ASA members in smaller hospitals delivering vital healthcare for their local community. It is the feedback from ASA members working in the city as well as those working in rural and regional areas where chronic workforce issues were so brutally exposed in a Royal Commission that highlighted the direct impact on patients of a system failing to ensure there is a workforce where it is needed.

1.5 Short-Term Fixes, Long-Term Pain

Instead of a long-term strategy, NSW Health continues to adopt short-term fixes that cost the people of this state more in the long run.

There are three clear examples in:

- Failing to fix an award that is broken and encourages anaesthetists to choose VMO arrangements over staff specialist employment.
- Relying on locums instead of encouraging, by adequate incentivisation, anaesthetists to work permanently and/or regularly in rural and regional areas.
- Paying for private facilities to undertake the surgical work of the public hospitals, instead on investing in the public health system capacity.

On top of this, the system is rife with non-standard agreements entered into by individual hospitals, either with or without the Ministry's blessing, to try and stop the haemorrhage, which are hidden from public view and obscure the true costs being imposed on the public health system.

In the context of anaesthesia services, Staff Specialist agreements or Awards in other states are far more competitive to attract and retain the staff specialist workforce essential to running and keeping a Health Services together. Staff Specialist employment provides a stable and cost-effective specialist workforce, and leadership and contribution through the clinical support activity required to underpin innovation in the health system. If NSW Health

retains the current shift in anaesthesia workforce towards a purely VMO approach, then it will become mandatory to pay for clinical support activity at sessional VMO pay scales. While some hospitals pay for some clinical support activities delivered by VMOs, they fall well short of the benchmark set by ANZCA of a departmental average of 30% clinical support time. This 30% excludes administrative duties.

The failure to modernise the Award and agreements and invest in an adequate specialist workforce by NSW Health has defined the state of play. The ASA believes that a majority of newly trained specialists in NSW are choosing VMO work arrangements, and/or are leaving NSW Health and entering the private health space.

This does not have to be the case.

Feedback from the ASA survey noted that it is not a case of exceeding other local pay arrangements. It is the size of the gap that is the issue. *'Many people would consider being staff specialists if there wasn't such a huge gap in remuneration between VMOs and staff specialists'*. This is particularly so for new consultants where there are only two pay levels for VMOs, but six for staff specialists. New staff specialists take 4 years to reach their maximum pay prior to being appointed as a senior, whilst VMOs only have one non-senior VMO pay scale and thus access that immediately. Whilst hospitals can employ staff specialists at a higher level than their entitlement under time served, in reality this does not happen.

The issue is not with there being a VMO workforce. In section two of this submission, we outline the benefits that VMO arrangements bring to the health care system in this state. In fact, the VMO workforce in NSW will be integral to meeting current and future capacity, capability and sustainability measures referenced in Terms of Reference F for this Special Commission of Inquiry.

The issue is that there is no other realistic option for specialist anaesthetists other than working as a VMO. It is the loss of balance that is the issue.

Staff specialist and VMO arrangements offer different types of benefits to the system. Making the most of those arrangements requires a balanced approach that is currently not being achieved.

Likewise with no flexibility in the Award to recognise the unique challenges of working in rural and regional areas, provision of anaesthesia services to multiple rural and regional areas is heavily dependent on fly-in, fly-out arrangements with locums. Similarly, there is difficulty recruiting in outer metropolitan areas due to an award with levels that rewards departments with higher private billings, and no flexibility in the award to address this.

Any search of locum anaesthesia postings in NSW will reveal offers of pay significantly more than that of senior anaesthetists in Staff Specialist positions. These inflated rates exclude the payments to locum agencies.

Locums serve an essential purpose, but they are not there for rural and regional communities to build a robust and reliable health service for all seasons. The few local anaesthetists left shoulder more and more of the burden of both the clinical work and administration required to keep things running.

NSW Health continues to choose to use the more expensive locum band aid solution instead of investing in a more stable, permanent workforce.

1.6 Public Patient Surgery in Private Hospitals

One alternative to delivering elective surgery in an environment where specialists are fleeing the public hospital system is to pay private facilities to take on this work. This is often referred to as Collaborative Care, Public Patient Surgery in Private Hospitals, or just Public in Private (PIP).

However, this adds to the cost the public hospital has already undertaken in initially caring for the patient by adding the costs to create administrative structures reaching into the private hospital setting.

The public hospital then adds the cost of paying for access to the facility and all staffing costs associated with the operations to their own budget. There is no evidence that this results in better outcomes for patients. There is evidence in the form of contracts showing the remuneration of clinicians employed to do the work, particularly surgeons, that it costs more for taxpayers.

A Public in Private model may be appropriate or required at times to meet shortfalls in the public health care system. However, it is important that PIP does not come at the expense of longer-term investment required to build public health system capacity in NSW. In section three of this submission, we identify significant short comings with the Public in Private model as it currently used across Australia.

Every time NSW Health encourages a specialist to leave the public hospital system, and relies on locum contracts, or a Public in Private model, they spend more money for no investment in the NSW Health System Capacity.

This is further compounded by the uncaptured cost of turnover of anaesthetists. There is no apparent effort to consider the cost of a highly trained specialist taking their skills to work elsewhere.

One attempt at a comparison might be to use the figures developed by health systems researchers at the Stanford Medical Centre, though this was in the context of assessing the cost of physician burnout. In work published in BMC Health Services Research, Hamidi et al[1] reported that the full cost of recruiting a specialist fell between $USD 268,000-957,000 depending on specialty and experience.

The study notes that 13% (61 of 472) physicians studied left between the two sample periods. This comes with enormous costs.

In the absence of direct comparable work in NSW, there should be caution interpreting these figures which are from a different healthcare setting.

Nevertheless, in the IRC dispute noted above, the Department of Anaesthesia at The Children's Hospital at Westmead noted an effective staff turnover rate approaching 58%.

The short-term fixes pursued by NSW Health instead of addressing the failing Award is costing taxpayers more money for no increase in care.

The failure to take steps to attract and retain a sustainable workforce adds magnifying costs that are not being counted.

1.7 Failing the Public with Secret Deals

Direct feedback from ASA members highlights a further distortion in the system driven by hospitals seeking to create arrangements to prevent the exodus of the Staff Specialist workforce – special deals.

These arrangements appear to rely either on interpretations of provisions created under NSW Health Policy Directives that allow for allowance payments recognising onerous work or just individual agreements from hospitals to effectively guarantee a level of pay to specialists.

However, some arrangements come with a condition requiring absolute secrecy regarding their existence.

The ASA has been advised by members that these arrangements to try and address inadequate conditions must be kept hidden under a threat of the agreement being torn up. On some occasions this is a result of the hospital seeking to keep the arrangement quiet. In other cases, it appears to be a result of Determinations entered into by the Ministry with a stipulation for total secrecy.

[1] Hamidi, M.S., Bohman, B., Sandborg, C. *et al.* Estimating institutional physician turnover attributable to self-reported burnout and associated financial burden: a case study. *BMC Health Serv Res* **18**, 851 (2018). https://doi.org/10.1186/s12913-018-3663-z

The result is a lack of transparency that makes it impossible to understand how money is truly being spent on the workforce.

The public has a reasonable expectation that public funds should come with public accountability. NSW Health is dependent on practices that obscure spending to prop up a system driving specialists out of the system.

Award reform that provides transparency and the capacity for clear public accounting of finances is imperative if there is a desire to manage public money.

1.8 Simple Award Solutions to Create a Sustainable Workforce

Modernising the Staff Specialist Award is one simple step to spend public money more efficiently. This is not a solution to increase health costs – the state is already pursuing options that cost more.

The requirements for Award reform can be delivered by starting with some simple principles:

- A modern Award must reflect the actual work done.
- A modern Award must start from a shared understanding that people are our greatest asset, not the buildings left empty without them.

The practical measures that follow from this are also very simple. They are simple enough that most other states and territories have already begun implementing these. NSW is being left behind.

Examples from other states that show the way forward include:

- The arrangement for base pay must be competitive with the healthcare landscape across the country as it applies to specialists. It is not appropriate to compare to different sectors doing different work.
- Direct hour-to-hour pay for extra work done has to be flexibly delivered in the form of overtime payment, on-call, recall and digital recall.
- Allow flexibility within the Award to provide additional incentive to work in vulnerable areas such as rural and regional locations, or niche areas where requirements for very particular skills amongst practitioners challenge recruitment and retention.
- Recognise the requirement for a baseline standard of at least 25% of the staff specialist role in clinical support activities to enhance the potential to keep optimising the health system and ensure ongoing training of a future workforce.
- Reframe the Award to highlight a commitment from all parties to enshrine important workplace conditions such as protection from the impacts of fatigue and bullying as a crucial step to improve NSW Health's reputation as a potential employer of choice.

- Recognise workplace entitlements as an expectation that NSW Health must meet, with additional workforce resources to maintain access to entitlements rather than denial of entitlements.
- Enshrine clear understandings of expectations of reasonable workplace conduct by both Specialists and NSW Health to encourage a practice of open dialogue and clear communication to solve challenges together.

1.9 Rebalancing the Workforce to Maintain Staff Specialists in the System

All too often change is associated with cost. However, a focus on short-term fixes is the fundamental problem seeing longer-term costs spiral. Changes now can set a path towards sustainability that will leave NSW better placed in 5-years' time.

It is entirely predictable that changes to encourage a rebalancing of the workforce, to maintain Staff Specialists in the system, can deliver:

- An overall reduction in workforce-associated costs related to employing Specialists.
- Increased availability of staff in public hospitals to avoid the need for more expensive Collaborative Care models.
- Simpler Award structures that can be administered more efficiently rather than bloated workforce systems.
- Enshrining adequate time and resources for clinical support activities that sets NSW Health on a path to drive higher quality clinical care and more effective models of care through research, clinical governance, and education. Advances in care and a readiness for innovation by having workforce devoted to these activities are essential to containing costs into the future.
- Enshrining adequate time and resources for clinical support activities is also essential to ensuring timely training of the anaesthesia workforce that is critical to all perioperative care across the state. At present a lack of available training opportunities and supervision partly related to workforce issues acts as a bottleneck in the system.
- Simplification of Award arrangements in other jurisdictions has permitted a renewed focus on optimised pursuit of Activity-Based Funding from the Commonwealth to better support the state finances. NSW is missing this opportunity.
- A stable workforce drastically reduces the costs of staff turnover. Unaccounted for at present, the impact of solving this problem equates to hundreds of millions of dollars saved over the forward estimates.

1.10 Conclusion

Patients across NSW are facing delays in elective surgery and operating sessions going unused. In a challenging medical workforce situation across the country, NSW has been left more vulnerable by discouraging anaesthetists from working in the public hospital system.

Simple steps to modernize the Award to compete with other states represent one crucial step to set up NSW for future success and offer some hope of constraining the health budget over the longer term.

Measures taken today to stop the haemorrhage of anaesthetists and other specialists from the public hospital system can deliver massive savings to the future health budget while also advancing the quality of clinical care. These savings would then create a tremendous opportunity to invest across the health sector in an integrated fashion for the benefit of all in the community.

2. Anaesthetist Visiting Medical Officer (VMO) Workforce

This part of our Submission is directly relevant to Terms of Reference F:

The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services.

In section one of this submission, we argue that a change in direction is required to restore an appropriate balance to the anaesthesia workforce in the public health care system in NSW, offering all the advantages of a mix of Staff Specialists and Visiting Medical Officers (VMO) working on behalf of the community. In this section we look at the issue of VMOs and the benefits this workforce brings to the health care system in NSW.

2.1 VMOs are also Integral to the Health Workforce in NSW

The Anaesthetist VMO workforce in NSW is integral to meeting the current and future capacity, capability and sustainability measures as referenced in Terms of Reference (TOR) F of this Special Commission of Inquiry.

The ASA is disappointed, that in these terms of reference, VMOs are grouped with 'other temporary staff arrangements' such as the use of locums and agency staff.

This in effect could not be further from the truth and appears to be an error in the understanding of the role of the VMO in the staffing arrangements of most NSW public hospitals, both in metropolitan and regional areas, from tertiary centres to small community hospitals.

In most NSW hospitals the anaesthetic VMOs are a permanent body of staff with a regular commitment to several sessions per week and generally on quinquennially reviewed and renewed contracts.

Many anaesthetic departments are in fact primarily, if not exclusively, staffed by VMOs who undertake some or all the usual administrative and other non-clinical roles including supervisors of training, junior medical staff education and supervision, quality assurance, governance and rostering roles, including as Head of Department. Historically, larger metropolitan tertiary centres have tended to have a greater ratio of staff specialists, although as outlined in the previous section, this is currently under threat.

This commitment is most certainly not temporary staffing and is the backbone of the senior anaesthetic workforce in non-tertiary, and some tertiary, hospitals in NSW.

VMO anaesthetists are indispensable to the specialist medical workforce of NSW Health. They work with and compliment the Staff Specialist workforce to ensure provision of a high-quality service to patients that is adaptable and flexible.

2.2 The Value of VMOs to the Health Care System in NSW

VMOs offer a highly skilled, highly motivated, and flexible workforce.

Many VMOs work across public and private sectors and can adapt to changes in service requirements, filling gaps in rostering in peak times, covering gaps left by leave, and taking unpaid leave during slowdowns.

VMOs work based on an hourly rate without any form of paid leave entitlement. If they are not working, they are not paid. As they do not receive any other benefits or entitlements, the cost to the health system of sessional VMOs can be similar to staff specialists. Inherent in this arrangement is a tolerance of more flexible working hours as they are paid for the time they are there. Not unreasonably salaried staff specialists are more likely to be less flexible, as they are not paid for additional hours worked.

VMOs can assist with fulfilling on call roster commitments which are onerous if left entirely to staff specialists and would contribute to the burnout currently manifesting as an exodus of staff specialists from, and inability to recruit them to, NSW public hospitals.

Additionally, VMOs are involved in teaching and supporting junior medical staff, medical students, and specialist trainees. Indeed, in many departments VMOs are appointed as supervisors of training.

Many VMOs practice between the public and private sectors and across several healthcare campuses, bringing a 'cross pollination' of ideas, techniques, and perspectives, broadening the scope of influences and expertise in the departments in which they work.

It must be acknowledged that currently all anaesthetists working in NSW Health and public hospitals, including VMOs, do so at some considerable financial disadvantage compared to the equivalent hours worked in the private sector. This contrasts with other states where public hospital awards are competitive with the private sector.

This concession is made voluntarily, generally with a mind to social and community responsibility, training our next generation, an interest in furthering knowledge through research, and a genuine desire to uphold the values and standards of medical care in our communities.

Many medical practitioners in public hospitals work many hours beyond those for which they are paid to uphold the above stated aims. To just get through the workload many senior clinicians work extraordinarily long hours, many unpaid.

Currently in NSW this relationship has been degraded by the actions of NSW Health and/or by administrators in some Local Health Districts (LHDs) and individual hospitals.

There are well known incidents of individual hospitals holding off sending VMO renewal contracts to entire departments until only a few days before current contract expiry, including sending them on Christmas Eve.

These contracts contained changes to work and remuneration conditions, and this was widely seen as a planned deception to ensure that the VMOs had no access to legal advice from professional bodies prior to needing to sign to ensure continuity in rostering and care of patients.

As example, some hospitals have instituted weekend 'rostered' (rather than on call) sessions for VMOs and then taken advantage of the unintended wording in outdated agreements that do not mention weekend rostered shifts, allowing administrators to consider weekend rostered shifts the same as weekdays, so not paid at a loading or on call rate.

NSW offers poorer remuneration with outdated award structures compared to other states, while increasingly busy hospitals stretching the same resources thinner and thinner results in staff burn out.

2.3 Recruiting and Retaining VMOs

A streamlining of processes between LHDs may be helpful to remove barriers and encourage VMOs to consider expanding their service provision. Currently the accreditation process must be repeated for each hospital, often even within an LHD. However, this should not be a tool to deploy VMOs away from their 'home' hospital, but rather to make it easier for the VMO to consider taking up other roles.

The accreditation, appointment, and review processes need to be examined to remove waste. The current processes are time consuming for both VMOs and their managers. Some hospitals require VMOs to complete the entire application paperwork every 5 years, despite the hospital already having most of that information on file. Reappointment processes need to be better targeted to only include information that is required. Time is wasted reinterviewing VMOs who have worked less than 5 years in a department. Annual reviews are poorly structured and are mostly a tick box exercise that wastes valuable time and resources. These need to be reviewed to ensure they are purposeful and of use to both VMOs and hospitals. Similarly mandatory training modules need to be targeted and of use to both VMOs and the health system. VMOs see great value in the treatment they offer patients and

are often frustrated by processes that reduce the amount of time they can devote to patients.

NSW Health currently uses nine electronic medical record systems (EMR), six patient administration systems (PAS) and five pathology laboratory information systems (LIMS).[2] This can be extremely difficult for doctors to navigate effectively when they work across numerous hospitals that may not have the same medical record systems, even within the same LHD.

Just this month it was announced that a Single Digital Patient Record (SDPR) program will be rolled out, beginning in the Hunter New England LHD, so that healthcare teams will be able to use the same digital clinical system to access patient information, record the care they provide, order diagnostic tests, and manage medications, no matter which public hospital or community healthcare facility they work in. The overall implementation timeline is anticipated to be 6 years up to 2029-30. Nevertheless, when it is finally rolled out, this will be hugely beneficial for patients and practitioners alike and will support consistency and continuity of care, particularly for patients receiving care across multiple NSW Health settings.

As mentioned elsewhere, VMOs are often working in the public system at a significant discount to what they would earn in the private sector. Offering conditions and remuneration that are competitive with that sector would increase retention and attraction of staff. Other states that have done this have seen the attraction and retention of quality staff. Strategies could include:

- Allowing initiatives such as salary sacrifice or access to long service leave may be attractive as retention strategies for VMOs.
- Ensuring payment of non-clinical roles in departments. Many VMOs are involved in the non-clinical aspects of managing the anaesthetic department, such as rostering, teaching, tutorials, supervisors of training or QA. All roles that are time consuming, yet it is hospital dependent whether remunerated time is allocated for these essential activities.
- Better remuneration of on-call requirements. The current on-call payments for anaesthesia reflect a time when fatigue management wasn't taken seriously. Staff would work hours overnight and still turn up to work the next morning. The emphasis on fatigue management makes scheduling work the next day difficult. On-call requirements in public hospitals thus impact on the ability to earn money the next day. The current hourly rates do not reflect this reality. This reduces the attractiveness of working in the public system. Some rural locations have negotiated solutions including protected non-clinical time the next day, but these have unfortunately been removed in recent years. In addition, the increasing superannuation guarantee rate has resulted in an increasing

[2] *NSW Health taps Epic for statewide, single digital patient record.* (n.d.). ITnews. https://www.itnews.com.au/news/nsw-health-taps-epic-for-statewide-single-digital-patient-record-588153

reduction in the real value of payments for callbacks, as they do not attract superannuation.

- The adequate indexation of rural support payments. These have not been indexed and need to be refreshed and indexed annually to attract staff to rural locations.
- Rates of pay for both sessional VMOs and Staff specialists remain uncompetitive compared to other jurisdictions. Anaesthetists can earn more by moving interstate or to the ACT, which some do. This is particularly problematic in border areas. It also makes it increasingly difficult to attract staff from interstate or overseas to fill workforce shortages. This is evident in AHPRA statistics, where specialist anaesthetist numbers in NSW have only increased 1.83% in the 12 months to September 2023, whilst the rest of the country has increased double that at a rate of 3.63%.
- Greater and more positive engagement with VMOs. VMOs represent a highly skilled and experienced workforce. They have a lot to contribute to the health system, and the ability to contribute more than they currently do. Unfortunately, interactions with management have at times been less than positive, and at times antagonistic. This has resulted in VMOs choosing to leave hospitals, or the system entirely. Improving the culture between VMOs and managers at all levels, will greatly help in the attraction and retention of specialist anaesthetists.

3. The Provision of Anaesthesia in Rural and Regional Areas

This part of our Submission is directly relevant to Terms of Reference F:

The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services.

And Terms of Reference H:

New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation.

3.1 Background

In Australia, anaesthesia is usually provided by specially trained medical doctors who have completed a recognised speciality training program in anaesthesia and have Specialist Registration with Ahpra ("specialist anaesthetists").

Anaesthesia provision in some areas, usually smaller rural centres with small and less complex caseload, may be provided by suitably trained non-specialist anaesthetists (GP Anaesthetists or Rural Generalist Anaesthetists, RGAs). These doctors are specialist medical practitioners working in rural communities who have both a General Practice Speciality qualification and an advanced skill in Anaesthesia recognised by the Joint Consultative Committee of Anaesthesia and/or the Doctors' credentialing body for Scope of Practice.

It is important that all providers of anaesthesia, whether specialist anaesthetists or GP anaesthetists (a GPA), should undergo appropriate training, credentialing, and determination of scope of practice. Providers of Anaesthesia need to work within their scope of practice, be rostered to work safe hours (including on call) and be able to maintain clinical currency and meet Continuing Professional Development (CPD) requirements

As will be outlined in section 5 of this submission, a shortage of specialist anaesthetists in Australia may be developing. What is clear however, is that there is a shortage of specialist anaesthetists in some areas. There are also areas within Australia without the surgical volume to support a specialist anaesthetic workforce, which rely on other skilled craft groups such as General Practice.

The 2016 Australia's Future Workforce publication for the Department of Health showed a specialist to population ratio of 1:4594 for capital cities and major regional centres while the ratio for smaller towns and remote areas is 1:83000.

It is acknowledged that it is difficult to recruit and retain both specialist and non-specialist anaesthetists in some areas. Contributing factors include some of the following:

- Varying degrees of professional and social isolation.
- The broad range of skills required of the anaesthetist in a rural community.
- A heavy workload including extensive 'on call' commitments.
- Variable working conditions including lower remuneration and lack of access to substantial private practice.
- Limited access to intensive care, subspecialty anaesthesia referral and administrative support.
- Difficulty in obtaining necessary ongoing continuing medical education.
- Difficulty in obtaining leave.
- Limited employment and educational opportunities for partners and other family members.
- Lack of availability of extracurricular activities.

In these areas of shortage of trained anaesthetists both specialist and non-specialist anaesthetists may provide the anaesthesia services, with local factors and complexity determining the balance between the providers.

3.2 Recruitment and Retention of Anaesthetists in Rural & Regional Areas

In assisting the recruitment and retention of anaesthetists in rural and regional areas, the following must be addressed:

- Anaesthetists must be appropriately informed about the context sensitive issues of the proposed practice.
- For employed anaesthetists, prospective employers should provide an attractive employment package that considers salary and non-salary components that incentivises rural and regional work. Remuneration should be commensurate with the responsibility and work undertaken and should be competitive with remuneration packages offered in major centres and interstate.
- Remuneration and Conditions of employment need to ensure there is adequate compensation for the above factors that make recruitment difficult, and incentivise anaesthetists to work in rural and regional areas
- For self-employed anaesthetists, practice should likewise incorporate attractive salary and non-salary components, commensurate with the responsibility and work undertaken, which should be competitive with remuneration packages offered in major centres and should adequately compensate for the above factors that make recruitment difficult.

- The provision of anaesthesia and intensive care facilities must be to the standard prescribed by the Professional Documents of the Australian and New Zealand College of Anaesthetists.
- Rostering must reflect the Australian Society of Anaesthetists' Position Statement on 'The Provision of "Out of Hours" Anaesthesia Services' (PS01).
- Mentor support must be available from experienced colleagues either locally or from a base, metropolitan or city hospital to prevent professional isolation
- Regular periods of skills maintenance are supported with leave and backfill for local services.
- Guaranteed leave with appropriate locum cover must be available.
- Access to educational facilities and activities such as libraries, morbidity and mortality reviews, anaesthesia incident monitoring reviews, journal reviews either locally or from a distance, and web-based and distance learning must be available.
- Involvement in hospital activities through representation on relevant committees should be encouraged and facilitated.

3.3 Role of Anaesthesia Providers in Rural and Regional Areas

In rural and regional areas, anaesthesia can be provided by specialist anaesthetists and/or Rural Generalist Anaesthetists (GP anaesthetists), as determined by local factors, complexity, and credentialed scope of clinical practice.

In relation to non-specialist/Rural Generalist Anaesthetists (GP anaesthetists), the ASA believes that:

- Non-specialist anaesthetists should be medical doctors who have undertaken specific training and whose maintenance of knowledge and skills complies with the requirements of the Joint Consultative Committee on Anaesthesia (JCCA) or its equivalent.
- Those Rural Generalist (GP) Anaesthetists maintain an anaesthesia workload consistent with the maintenance of clinical skills and case mix required for their scope of practice.
- The non-specialist providers are enrolled in a suitable continuing professional development programme that maintains their anaesthesia knowledge and skills.
- There is cooperation between specialist and rural generalist (GP) anaesthetists where anaesthetic services are met by a combination of the two providers.
- On-going clinical privileges should take account of historical services provided by Rural Generalist (GP) anaesthetists in addition to current availability of specialist anaesthetists.
- Where 'out of hours' cover is provided by rural generalist (GP) anaesthetists, access to appropriate clinical experience to facilitate the maintenance of necessary skills is provided.

We note that in 2023, a new diploma of rural generalist anaesthesia (DipRGA) was implemented in Australia, developed collaboratively by the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practitioners (RACGP) and the Australian and New Zealand College of Anaesthetists (ANZCA).

The new DipRGA replaces and enhances the prior JCCA training curriculum which has underpinned anaesthesia services to Australian rural and remote communities for nearly 30 years and is focussed on the needs of rural and remote communities for:

- Elective and emergency surgery
- Maternity care
- Resuscitative care for medical illness or injury
- Stabilisation for retrieval.

The DipRGA supports rural generalist anaesthetists working within collaborative teams in geographically isolated settings.

In relation to Specialist anaesthetists, the ASA believes that:

- Specialist anaesthetists' mentor Rural Generalist Anaesthetists (GP) anaesthetists, with cooperation between Specialist and Rural Generalist Anaesthetists (GP anaesthetists).
- The Specialist Anaesthetists maintain their skill and expertise through a recognised and AHPRA approved continued professional development standard.

4. Public Patient Surgery in Private Hospitals

This part of our Submission is directly relevant to Terms of Reference A:

The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.

Terms of Reference B:

The existing governance and accountability structure of NSW Health, including the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW.

and Terms of Reference F:

The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services.

As an organisation, the ASA is proud that Australia is one of the safest countries in the world to undergo surgery, in both the public and private sectors. ASA member anaesthetists provide care across all parts of the patient's peri-operative journey; pre-operative, intra-operative and post-operative. They provide this care in conjunction with surgical colleagues, nursing staff and allied health professionals to ensure the best outcomes for patients.

In the post-COVID era, there has been an increasing trend to outsource surgery and other procedures on public patients to the private sector, often referred to as 'Public in Private' (PIP). At times, these arrangements may be required to meet shortfalls in the public system. However, it is important that PIP is not at the expense of longer-term efforts to build capacity in the public health system in NSW. We need to continue to train registrars and nursing staff, investing in both physical and human capital of our health system.

4.1 Identified Short Comings with the Public-in-Private model.

4.1.1 Patient selection

Patient selection is key to a successful PIP model. Unfortunately, in some cases selection has been driven by conditions within public hospitals, rather than by the selection of patients most appropriate to such a model. This has resulted in complex patients, that require significant resources, being sent to private hospitals that don't have the appropriate resources, because there is no access to any care in the public hospital due to lack of high dependency beds or other resources. This increases risk for the patient and treating team, and potentially results in increased morbidity.

4.1.2 Preoperative Care

Anaesthetists play an important role in the preoperative assessment and optimisation of patients prior to surgery. This may occur in a pre-anaesthetic clinic, which is common in a public hospital setting, or by the individual anaesthetist in the private setting. Unfortunately, public-in-private models have disrupted this care. This has resulted in situations where clinicians in the public have made decisions without any knowledge of the systems or resources in the private hospital, assessments have occurred but not been communicated to the private hospital clinician, or no assessment has occurred at all. This increases risk for the patient and treating team. Prehabilitation and patient optimisation is an important part of the peri-operative process, and it is essential that any PIP model incorporates this component of the patient journey.

4.1.3 Fragmentation of Care

Some PIP models take patients away from their normal care provider. Patients are best treated by being looked after by their usual team, who best understand their clinical issues and needs, and can provide the best follow-up for their patient. Unfortunately, some PIP models even take patients out of their geographical area to be operated on by surgeons they have never met.

4.1.4 Access to medical Records

A frequent complaint of anaesthetists is the lack of access to medical records. The safe delivery of anaesthesia is dependent on the detailed knowledge of a patient's medical and anaesthesia history. Removing patients from a system that has detailed knowledge of a patient, to a system that has never looked after them, increases clinical risk. Unfortunately, this has often been accompanied by lack of access to the records in the original hospital by the clinicians in the private hospital treating the patient.

4.1.5 Peri-operative Teamwork

Operating teams that work together on a regular basis have been associated with improvements in clinical outcomes. The ad-hoc nature of many PIP models often results in teams who rarely or have never worked together, thus increasing clinical risk.

4.1.6 Postoperative Care

The model of postoperative care is different between public and private hospitals with respect to anaesthesia. In the public, junior medical officers are usually present to assist with postoperative care. In the private system, this care is provided by the operative anaesthetist. Remuneration models implemented since the pandemic have typically not recognised this difference. There has also been concern about responsibility where a patient needs to return

to theatre. Given many anaesthetists have refused to participate in PIP models, this has resulted in confusion and conflict when the on-call anaesthetist does not participate.

4.1.7 Training

Training of our future workforce is an important responsibility of public hospitals. Every patient moved to the private system is a training opportunity denied to our trainees. This is particularly so where procedures are in subspecialties where there is limited opportunity for training, such as cardiac and paediatric anaesthesia.

4.1.8 Remuneration

Remuneration models have overall been unacceptable to many anaesthetists, resulting in low take up. Remuneration has typically been less than usual remuneration in the private, less than remuneration offered in other states, and at times lower than usual conditions in the public system. It has failed to consider the increased complexity associated with the PIP model, and the greater time involvement of the operative anaesthetist in perioperative care in the private system. It has also been less than that offered in other surrounding states. The arrangement of using private hospitals as the intermediary has also been difficult at times, and some anaesthetists have concerns with having to sign contracts with private hospitals. It would be preferable if the ministry or LHDs handled this aspect, rather than outsourcing this to private hospitals.

4.1.9 Devaluing of Private Hospital Health Fund Cover

Private patients, who access the private hospital system, have contributed significant resources to access that care, including health fund premiums, health fund excesses, pharmacy and ancillary fees, and medical gaps. Allowing public patients to access the same services at no cost, devalues the significant expense contributed by private patients to access the same service.

4.1.10 Professional Issues

At times there has been significant confusion in the profession regarding medical indemnity for PIP patients, which has contributed to uptake of PIP. There has also been concern regarding Quality Assurance processes, and the opacity of this process when morbidity or mortality has occurred.

Despite the best efforts of anaesthetists in both the public and private sectors, PIP as implemented by NSW Health falls short of what is required to support safe and high-quality care. In a survey to inform this submission, only 25.7% of anaesthetist supported public patients having surgery in the private system, and only 42.4% felt it added value to the health care system in NSW.

4.2 Improving Safety of Public in Private care

4.2.1 Improved clinical governance

LHD's need to have policies in place to ensure the highest standards of care are maintained. These policies need to address:

- Patient selection
- Access to clinical notes for the anaesthetist to review well in advance of the operating date. This can allow time to identify the patient's comorbid conditions, optimise these as appropriate, and ensure the patient is an appropriate risk for the planned facility
- Referral pathways for both the pre- and post-operative period to other medical specialities, and to allow the escalation of care to Intensive Care Unit's or other facilities as appropriate
- Dedicated nursing and administrative staff at both the referring public hospital and treating private hospital to assist in the screening process of patients and information sharing, with close coordination with the treating surgeon and anaesthetist
- Ensuring appropriate quality assurance pathways are in place to identify problems, review morbidity and mortality, and implement system improvements.

4.2.2 Surgeons should operate on their own public patients, in facilities where they would normally work

Surgeons have a pre-existing relationship with the patient and would have formulated a surgical plan for them. The continuation of this plan, in conjunction with the normal peri-operative team that they work with (anaesthetic, nursing and allied health staff), will optimise the outcomes for the patient.

Transferring patients across the state for surgery disconnects patients from their support networks, and if information is not well shared, increases the risk for patients. It also reduces the ability of regional areas to attract and retain nursing and medical staff by lowering the available pool of work.

The remuneration of anaesthetists for undertaking PIP work needs to reflect the challenging nature of it, and the nature of work in private practice. The treating anaesthetist is taking responsibility along with the surgeon for the pre-optimisation of the patient, as well as for aspects of their care in the post-operative environment. Public patients presenting through the PIP model often have complex comorbidities and have faced barriers in accessing specialist medical care to optimise this in comparison with private patients. Anaesthetists working in private practice have no access to paid annual or sick leave, and need to cover other costs like indemnity insurance, superannuation and practice costs.

5. Education and Training of Anaesthetists

This part of our Submission is directly relevant to Terms of Reference G:

Current education and training programs for specialist clinicians and their sustainability to meet future needs.

5.1 Anaesthetic Workforce Modelling

As late as 2019 the ASA was concerned about a potential oversupply of anaesthetists due to a significant increase in the number of medical graduates and anaesthesia trainees in the preceding years before this.

Health Ministers endorsed the National Medical Workforce Strategy 2021–2031, in December 2021. This strategy aims to structure and support the medical workforce in a way that ensures Australia can meet the current and emerging health needs of Australians. This Strategy notes several specialties, including anaesthesia, show signs of being in oversupply. Increasingly however, feedback from ASA members, and from numerous state and territory jurisdictions, does not support this assertion, at least as far as anaesthesia is concerned. We believe this applies in New South Wales also, including increasingly in hospitals located in large metropolitan centres.

In April 2023, the ASA engaged HealthConsult to update our existing ASA Member Survey and apply the new survey to gather data to inform development of a workforce model for Australian anaesthetists over a ten-year horizon.

This project aims to:

a) review, refine and roll out an updated survey to ASA members (and ideally, other anaesthetists that are not part of the ASA's member base).

b) develop a workforce projections model over a ten-year period, which will include new entrants into the workforce, attrition rates and projections of both workforce supply and demand.

c) understand the current demand and supply of anaesthetic services across Australia, including the number of anaesthetists practicing in metropolitan and regional areas, the mix of patients that use anaesthetic services, different service models and known or anticipated advances in technology that will impact anaesthetic practice.

While we had initially hoped to have the results of this workforce modelling available in November 2023, project finalisation has been delayed as we seek additional data sets from both Services Australia and the Department of Health and Aged Care. We now hope to have the results of this workforce modelling available in early 2024.

5.2 Increasing Trainee Throughput

The Australian Society of Anaesthetists (ASA) does not oversee the training of anaesthetists, but many of our members are involved through their roles within the Australian and New Zealand College of Anaesthetists (ANZCA) or their roles within public hospitals.

The ASA would note that ANZCA does not control the number of trainees. NSW Health can increase trainee numbers today, simply by funding more trainee positions within currently accredited hospitals. ANZCA does not accredit individual placements, and instead accredits hospital anaesthesia departments. It is thus NSW Health, the employer, that largely controls trainee throughput in NSW. The ASA would thus encourage NSW Health to monitor workforce needs and ensure that adequate funding is allotted to support sufficient anaesthetic training in NSW. The ASA is aware of many anaesthetic departments that are keen to increase registrar numbers, and there are many junior medical officers keen to pursue a career in anaesthesia. The trainee numbers supported by NSW Health has unfortunately become decoupled from workforce requirements in the past few years.

Subspecialty training, particularly cardiac and paediatric anaesthesia training, represent a potential barrier to increasing trainee throughput. However, again, NSW Health can easily overcome this by funding more registrar positions within these subspecialties. There is also the potential for NSW Health to fund training rotations within private hospitals, or to allow trainees to attend specific lists in the private setting, to attain the required volume of practice.

5.3 Maintaining High Quality Training

The high quality of anaesthesia services in Australia is the result of an excellent training program, and ANZCA is to be commended for this. This quality has been recognised by administrators and other craft groups, with anaesthetists increasingly supporting services outside the operating theatre, such as endoscopy, radiology, and interventional cardiac services. It is important that the safety gains achieved in these areas are maintained through ensuring adequate workforce to support these areas. It would be disappointing if the quality of these services was diminished by a return to lesser trained clinicians. Patients in these areas are becoming increasingly unwell with more comorbidities, interventionalists are increasing the scope of practice in these areas, and anaesthesia of these patients can be often challenging. The safety and outcomes in these areas benefit greatly from the highly trained anaesthetist workforce.

Accreditation of departments is an important part of ensuring quality training within our hospitals. NSW Health should value the input of Colleges with respect to accreditation requirements. Firstly, because excellent training sites generate excellent training, which then generates excellent medical practitioners who will contribute significantly to the health system over their career. Secondly, because consultant medical practitioners remember how

they were treated during their junior medical career. Consultant medical practitioners have opportunities outside of NSW Health, including private practice and interstate. Most of these opportunities provide employment conditions superior to that of NSW Health. If NSW Health is to attract a quality consultant workforce, then it would be prudent to provide conditions that encourage loyalty to the system. A positive investment in trainees is an investment in the future of the NSW health system.