New South Wales

Special Commission of Inquiry into Healthcare Funding

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Mr Richard Beasley SC
Commissioner
Special Commission of Inquiry into Healthcare Funding

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Dear Commissioner Mr Richard Beasley SC,

On behalf of the Royal Australasian College of Surgeons (RACS), we first would like to show our gratitude for the opportunity for an informal preliminary meeting (1 November 2023) with yourself and your team who are current conducting the *NSW Special Commission of Inquiry into Healthcare Funding*. We found it to be most constructive and we hope that our insights were of value. We look forward to continuing our engagement for the duration of this inquiry process.

Here is our first submission in what we have been informed will be a long process with several inquiries and other possible written submissions. We will follow the structure of your Term of Reference in order to provide what valuable insights based upon the experience of our Fellowship that we can. We followed your advice and structured our response to each of your sections in a simple to understand format as follows-

- Identifying the Problem
- Reasons for the Problem
- What is the Solution?

This Special Commission in our opinion may be an important case study for other states and territories to follow, critique, and to help improve their own healthcare system.

ABOUT THE RACS

RACS is the peak surgical organisation, and the leading advocate for surgical standards, professionalism and surgical education in Australia and Aotearoa New Zealand. RACS is a not-for-profit organisation which represents more than 7000 surgeons and 1300 surgical Trainees and Specialist International Medical Graduates across Australia and Aotearoa New Zealand.

RACS supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. RACS trains in nine surgical specialties, being Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery.

SECTION A: FUNDING AND DELIVERY

"…how the funding can most effectively support the safe delivery of... health services to the people of NSW…"

General Introduction: Prior to the pandemic close to 2.7 million surgical procedures were delivered in hospitals by highly trained specialist surgeons and other medical specialists with high quality public

hospitals providing equitable access.[i] But we need to identify the differences between how federal funds are distributed, and how our state funds in the case of NSW are being spent.

SECTION B: GOVERNANCE AND ACCOUNTABILITY

"… i. balance between central oversight and locally devolved decision making…"

Identifying the Problem

Rural Maldistribution: Based on the statistics from AIHW, at present approximately 29% of Australians live in rural and remote locations,[ii] but there remain problematic issues relating to collaboration and working across different healthcare jurisdictions and within. For example, rurally 'fly in and fly out' services are often solely within the private sector with the public sector suffering. Specialised areas like spinal work, neurosurgery and other smaller surgical specialties are becoming a crisis in NSW rural regions. A study conduct in 2020 showed that there is a maldistribution of medical practitioners (including surgeons) between the private and public sectors and areas of need,[iii] and better coordination between rural and metropolitan services are required. Locum services in NSW are broken and expensive, and other rural towns creating competition between Local Health Districts (LHDs). Obviously, it would be far preferable to have a sustainable workforce within each health district to reduce the need for locum coverage. The end result is a form of geographical narcissism with metropolitan surgical practices perceived as better than rural surgical practices. But if city hospitals have a social contract, then this can lead to improvement.

Reasons for the Problem

Metrocentric Funding Model, and Social Contract: The current funding model is flawed, for example, a research study conducted in 2021 found that funding associated with a trauma centre is metrocentric without any understanding for rural needs when a significant amount of trauma occurs in rural and regional locations.[iv] Level 1 restrictions focus on chest and head, but this is a clinical luxury in a metropolitan setting where there is an abundance of available specialists compared to the rural setting. This outcome is due to a bottom-line total funding approach as determined by the health ministry which prejudices rural patients and their local surgeons. There is also a lack of a social contract associated with 'fly in and fly out' services where private work is targeted in isolation often without any care provision to uninsured public patients. . Surgeons who leave a private patient are often not available for their continuity of care due to distance, leaving complications to public full-time staff. At the moment rural health is managed by metropolitan health department. One recommendation supported by RACS is that rural should have stand-alone department. Furthermore, according to the *Independent Review of Overseas Health Practitioner Regulatory Settings – Interim report*,[v] existing shortages within the specialist workforce could be improved under our current regulatory system for overseas surgeons or Specialist International Medical Graduates (SMIG) towards a more simpler, faster, fairer and less costly entry into our workforce.[vi] However, this deregulated solution proposed by the so-called *Kruk Report* to the government to fill vacancies in for example in rural and remote regions, takes doctors away from countries in greater need. Workforce fragilities exist for 57 countries globally which are experiencing critical shortages of trained surgical personnel according to the World Health Organisation (WHO).[vii] WHO's global (but voluntary) code of practice on international recruitment of health personnel as approved by Member States in the Sixty-third World Health Assembly Resolution WHA63.16 clearly states the following -[viii] "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers."[ix] This practice has been called 'poaching doctors from abroad', and deemed as unethical.[x]

Case Study: How successful a region is dependent upon their model of care. There is often a disconnect exist between LHDs and primary healthcare. The NSW Grafton Aboriginal care is a good model. Grafton has a multidisciplinary team funded at a relatively low cost, but ironically due to a lack of funding, they have been impacted when it comes to maintaining their services. Waiting list reduction post COVID is fine in the city, but within rural sites LHDs were transferring patients to the city, and if there are any complications local rural surgeons had to step in once the patients are transferred back to rural. The impact of rural to metropolitan transfers have also caused rural surgeons not to be able to sustain their profession. Wagga Wagga NSW has a good rating with regards to length of bed stay, however Wagga Wagga only succeeds due to their relatively small size, close collaborations, known healthcare units for a patient's post-op care and assistance. These models of care need to replicate at other rural and regional services and funded appropriately to maintain service provision. Another issue on concern is that credentialing between public and private hospitals are not always aligned, and as such causes major issues when considering public in private solutions with regards to provision of care.

What is the Solution?

Needs-base funding: A solution is that the whole is equal to the sum of its parts, neither more nor less. And there are various parts which require targeted needs-based funding assistance. Enhanced funding for rural and regional services and specialists are required to keep them in the regions. Their practice needs to be strongly supported to ensure they have viable financial careers and satisfying professional careers in these centres. This can be achieved by creating links between major regional and metropolitan hospitals allowing transfer of complex patients to that regional centre metropolitan home and allowing the regional surgeon to perform the surgery in metropolitan areas together with the metropolitan team, which ensures continuity of care when that patient returns back to their rural home. With regards to 'fly in and fly out' services, consideration should be considered to restricting provider number access to those who perform both private and public work in that location, including assisting with afterhours calls and coverage. Renumeration should also include costs for travel and accommodation within this orientated criterion of a public/private balance.

SECTION C: PUBLIC HOSPITAL ALLOCATION OF RESOURCES

"The way NSW Health funds health services delivered in public hospitals and community settings... allocation of resources supports or obstructs access..."

Identifying the Problem

Waiting Lists Backlog: Appropriate funding is required to help reduce public surgery backlogs and wait times[xi]. The January 2022 Australian Institute of Health and Welfare (AIHW) elective surgery wait list report shows long and growing waiting times for elective surgery in Australia's public hospital system. For example, AIHW data showed that the proportion of patients waiting more than a year for knee replacement surgery tripled from 11% to 32%, in just the last two years between 2020-2022[xii] (more updated data is required for 2022-2023 to see if there are any improvements). A number of studies has flagged that, for many patients waiting in line to have a critical operation who are in chronic pain, the delays in having surgery can be devastating.[xiii][xiv]

Reasons for the Problem

Outpatient & Medicare: A huge growth in cost shifting and Medicare billing in our public hospitals and outsourcing from public to private, are so much so that the proportions of funding can be extremely opaque. There is a lack of outpatients in public hospitals, and a growing reliance on privately run clinics. How Medicare rebates are accessed can unintentionally create an inequitable playing field with additional out of pocket charges, particularly when access to public care is not universally available.[xv] Private outpatients can have a profound negative impact on teaching surgical registrars and medical students as demonstrated in operating public in private. This is highlighted by

infrastructure differences between a public and private setting whereby public settings despite the lack in funding is designed to support registrars with staff support and indemnity.

What is the Solution?

Private in Public: Innovative ways of service delivery may be a solution in the short term. Consider how operative and post-operative care are provided beyond the public hospital. The capacity of smaller facilities in the private sector that may be underutilised in undertaking public lists to reduce the elective/planned surgery backlog should be explored.[xvi] This concept however causes significant issues that were largely unresolved during the COVID pandemic – including who assess the patient from an anaesthetic viewpoint , who reviews the patients postoperatively, who deal with complications, who covers the insurance, and who performs the surgery as those credentialed to work in the private hospital may not have rights in the public hospital and vice versa, amongst others. In addition, it significantly devalues private insurance as a product with the private system having to cope with the majority of planned surgery in this country so needs to be adequately supported and protected. COVID-19, and the increase of waitlists for elective surgery has compounded these difficulties.[xvii]

SECTION D: STRATEGIES TO MINIMISE OVERSERVICING

"…to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement…"

Identifying the Problem

Low-Value Care: This is potentially a contentious issue, however there are more anecdotes than actual data and evidence to support the proposition that some surgeons maybe gaming the system. Providing low-value care and unnecessary surgical procedures can impact MBS expenditure, public hospital waiting lists and costs, as well as potentially raise private health insurance premiums in the private sector.

Reasons for the Problem

Lack of Funding for Surgical Registries and College Research: The hypothesis is whether there is low-value care being practiced, or that there is a generation specific trend toward particular surgical procedures due to changing lifestyles, and an increase of specific or new forms of oncology or cancer related ailments. Despite some research efforts to investigate low-value care, however, we simply do not know holistically for certain.[xviii] Why? Specialist colleges like RACS and other surgical societies oversee surgical registries, however funding for staffing and technological instruments for analysis is very limited making it exceptionally hard to collate and analyses data taken from the field. Funding is required to explore how surgical registries can be better utilised and supported within a post-pandemic environment of long waitlists within both public and private hospitals.[xix]

What is the Solution?

More Funding for Surgical Registries and College Research: RACS can take on the task of exploring these issues, but more funding is required from the government in order to do so. RACS has a division called the Research, Audits and Academic Surgery (RAAS), and various committees like the NSW Committee and the Health and Advocacy Committee which are composed of active senior surgeons in the field who can provide clinical guidance to RAAS. RACS has also developed partnerships and stakeholder relations with organisations like Medibank Private, the Australian Private Hospitals Association, and the Australian Patients Association (APA) for this exact purpose so as to gain access to data for analysis and evaluation. For example, public hospital elective surgery data taken from the government and from a private sector third party can greatly assist in pursuing a fair and balance analysis. RACS is not a regulatory body, and nor are we designed to become one. Our remit in this context is purely clinical and scientific, in the pursuit of data which can assist us in

the continual training of our trainees and fellows in the interest of maintaining the highest surgical quality in public healthcare, safety and standards. However, this cannot be done without appropriate funding from government. Effective funding can help us with staffing and time so as to discover is there is a pattern relating to low-value care, or new ailments unique to our specialty which will require changes made to our education and training of new surgeons in the future. The need to forecast future surgical specialty training and their pipelines is essential, and the state of NSW can be used as a case study. Data and education are the important drivers to reduce low value care provision.

SECTION E: IMPROVE DECISION-MAKING

"…improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery…"

Rural Health Equity Strategy: RACS has acknowledged that some of RACS' own policies and systems were barriers in the past, for example in relation to the selection of trainees and SIMGs. RACS is addressing these barriers under the RACS Rural Health Equity Strategy, adopted in 2020. Long-term mechanisms must be put into place to address the specific barriers to attracting and retaining surgical trainees and surgeons in rural areas. Such a mechanism would leverage the Flexible Approach to Training in Expanded Settings (FATES) program which the NSW government can help advocate for continual funding from the Federal government[xx]. In addition, better procurement policies could be instituted, which was the background to prosthetic list reforms. It is important to ensure that surgeons have all the required equipment and resources to do their work effectively, but there may be procurement opportunities to purchase devices or items in bulk that may ultimately reduce health care costs.

SECTION F: EXPANDING SCOPE OF PRACTICE

"… ix. opportunities for an expanded scope of practice…"

Identifying the Problem

NSW Pharmacy Trial: In NSW there is a Pharmacy Trial whereby trained pharmacists can provide community access to important medications and treatments which was usually only available with a prescription. Pharmacies can access antibiotics without the need to consult a visiting doctor as an example of opportunities for expanding scopes of practice. The risk in the field of urology is relevant, and such concern has been raised by professional bodies in different states.[xxi] For example, bladder cancer can present symptoms not unlike a urinary tract infection or UTI, and if a pharmacist doesn't liaise with a specialist, there will run the risk of providing an incorrect prognosis and medication.

Reasons for the Problem

Mistaken Diagnosis: The risk of expanding the scope of practice in the field of urology is great. The example of bladder cancer being that it can present symptoms not unlike a urinary tract infection or UTI. RACS in unity with the Urological Society of Australia and New Zealand (USANZ) are in opposition to the implementation of unsupervised antibiotic prescribing authority for a pharmacist, with RACS having already endorsed a USANZ open letter to the Commonwealth Minister for Health.

What is the Solution?

Co-ordinated Team: We need to work collaboratively with pharmacists and nurses who are given an expanded scope of practice. The potential for misdiagnosis in relation to UTI with the introduction of antibiotics which can masked other conditions like cancer is too great a risk. Not only will this impact upon the lives of patients, but also on preventive cancers if detected early can reduce the financial burden on the NSW healthcare system. In principle, all prescriptions need to be conducted

within a co-ordinated team, inclusive of a surgical specialist. In addition, there may be opportunities for pharmacists to take on some roles of primary care, and for primary care especially in rural and regional area to take on roles of specialists (rural generalism), but adequate standards need to be applied, training occur, and there should always be a "team" approach so that multidisciplinary support is available and supported with adequate funding.

SECTION G: TRAINING FOR SPECIALIST CLINICIANS

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

Identifying the Problem

Training is Pro Bono: All training is conducted pro bono by our surgical fellows in the public setting. But there are growing difficulties due to the limited supply of surgeons who can train in the public sector, and the Medicare system which doesn't support their overtime resulting in senior fellows often seeking work in the private sector to reduce their heavy workload and be financially renumerated for their time in the private sector. In addition, there are strict criteria imposed by AMC regarding accreditation of surgical training sites. This limits that ability to produce surgeons, both due lack of sites and lack of surgeons to do the training. A close review of training site requirements needs to occur to maintain standards of care within the constraints of workforce related requirements.

Reasons for the Problem

Rural Mentor to Trainee Ratio: The problems associated with the poor mentor to trainee ratios is very evident in a rural setting. Training in rural areas is suffering as the mentor to trainee ratio suffers due to high demand. RACS could train two registrars in an area of need setting, but without the mentoring needed from a senior surgeon, the expertise will be lacking, and maintaining surgical standards will suffer in relation to the Australian Medical Council (AMC).

What is the Solution?

More Funding and Surgical Metropolitan to Rural Link: Government needs to assist with funding. RACS can help with more space and accreditation. Other systemic issues are Health Education and Training Institute (HETI) which has done some good work in this area, but the NSW health department doesn't communicate with HETI despite being in the medical doctor training space. This is a lack of effective co-ordination in this space. In a rural setting, training can be boosted with metropolitan surgeons 'fly in and fly out' services to assist with mentoring training of young trainees. There are medical schools and hubs in rural, but a gap exists in absence of a metropolitan link with rural. A surgical link will also translate into a training link. The more the trainees the greater the cohort which will counter problems associated with feelings of isolation with for example the creation of peer-to-peer study groups. Jurisdictions should have developed contracts that facilitate this exchange, but more information is required.

SECTION H: FUNDING INNOVATIONS

"... changes to scope of practice, workforce innovation, and funding innovation..."

Identifying the Problem

Block Funding is Flawed with Training: Block funding has been deficient when dealing with resources for training.

Reasons for the Problem

Pro Bono Stress and Litigious Environment: Most of our senior fellows provide pro bono work at their own time and expense when providing supervision to our trainees, and at a level of uncompensated stress. There has also been growth of a more litigious training environment which

places increasing pressure upon our supervisors. The College attempts to deal with any complaints or disputes within our cohort through mediation and conferencing as stipulated under our regulations[xxii] and Building Respect programs[xxiii]. But there has been a growing trend in Medical Defence Organisations providing legal support to trainees at no direct cost to them RACS has been informed, and which requires further investigation. Common complaints revolve around trainees not passing workplace competency assessments. The onus of proof often falls onto the supervisor with the training committees to justify their assessment of a trainee. The result is that more adequate time is required for assessments to be conducted. The compounding effect becomes a source of de-motivation for senior Fellows taking up teaching.

What is the Solution?

Shift from blocking funding to activity-based funding: The solution is more activity base funding is required to help manage the situation effectively. Equitable funding and support are required to protect the valuable time of our senior fellows and to effectively assist them as supervisors in training and education. The culture and behaviour of new cohorts are consistently changing year by year. More emphasis is being made as to work-life expectation, and the wellbeing of our new Trainees. They represent the next generation of mentors. Well-being self-awareness has in one respect been a welcome change to the College as RACS has introduced resources supporting flexible surgical training[xxiv] and partnered with Converge International[xxv].

SECTION I: OTHER CONCERNS

Inflation and Impact on Funding: A more holistic implementation strategy is needed, alongside national, state and territory government support. Inflation in relation to future funding needs to be taken into consideration.

Post-Pandemic and Elective Surgery: The January 2022 Australian Institute of Health and Welfare (AIHW) elective surgery wait list report shows long and growing waiting times for elective surgery in Australia's public hospital system. For example, the proportion of patients waiting more than a year for knee replacement surgery tripled from 11% to 32%, in just the last two years between 2020-2022 (more updated data is required for 2022-2023 to see if there are any improvements). Assurances must be made for surgical trainees to continue to gain appropriate experience in all competencies and that appropriate surgical standards are being met.[xxvi] Indemnity complications can exist if trainees are forced into a private setting with limited insurance protection normally provided holistically within a public setting.

First Nation People: Funding mechanisms should support policies to attract and retain surgical trainees and surgeons, particularly Indigenous surgeons, working on healthcare issues more common in Indigenous communities, and which improve the maldistribution of the workforce.

Protection of Title: Speedy change of NSW legislation is required in alignment following the passing of the Queensland *Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023* protecting the title of 'surgeon.' More funding is required for policing, penalties, and compliance for those who have not undertaken accredited specialist training in surgery and advertising themselves using terms such as 'cosmetic surgeon'. RACS will continue negotiations with the AMC on education standards, training, and endorsement[xxvii]

Multiple Posts: Multiple public hospital posts for the one surgeon are not ideal. A more balance solution would be for a surgeon to have one major, and one minor post as the most appropriate maximum.

Workforce Data: Ideally workforce data should be government run and funded. This data can then be shared with RACS who can assist with analysis based upon our expertise in the surgical profession as the peak surgical body in the country.

Nurses: As the operating theatre is a shared professional environment, an integral party of the surgical team are nurses. Government funding of operating room nurses is a requirement. For example, post anaesthesia care unit (PACU) nurses are essential as there is no point sorting out the medical workforce in surgery without the required nurses to assist.

Prevention strategies: Early detection in surgical and use of a holistic medicine is integral when attempt to prevent ailments as an early stage of a patient. For example, ear, nose, and throat screening for children.

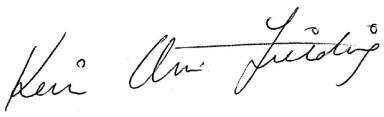
Long Service Leave Retention: Ensuring the provision of long service leave entitlements across state borders to attract more surgeons into NSW rural, and remote locations would greatly incentivise the workforce within these regions of need. Furthermore, this should apply to all entitlements including maternity and paternity leave for trainees.

CONCLUSION

In the context of this NSW Special Commission which may have far reaching implications upon the country as a whole, RACS supports an ongoing relation with government as the peak surgical organisation in the state of NSW and Australia. The consistent theme within our preliminary submission demonstrates the need for more astute spending and financial management of funds which will have a far reaching and long-term impact upon the state of NSW and the country as a whole. These are as follows-

- More targeted and needs-based funding
- Link between metropolitan and rural hospitals
- More structured collaboration and co-ordination

Yours sincerely,



Associate Professor Kerin Fielding
RACS President

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RACS Councillor, Chair Health Policy and Advocacy Committee

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[xiv] RACS Federal Election Statement 2022, p.4

[xv] RACS Submission, National Health Reform Agreement Addendum 2020- 2025 Mid-term Review, p.6

[xvi] RACS Submission, National Health Reform Agreement Addendum 2020- 2025 Mid-term Review, p.4

[xvii] RACS Submission, National Health Reform Agreement Addendum 2020- 2025 Mid-term Review, pp.6-7

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