



Introduction

The Commission identified four themes in its Interim Report:

Themes	Health reform areas
Taking responsibility	Building good health and wellbeing into our communities and our lives
Connecting care	Creating strong primary health care services for everyone Nurturing a healthy start to life Ensuring timely access and safe care in hospitals Restoring people to better health and independent living Increasing choice in aged care Caring for people at the end of life
Facing inequities	Closing the health gap for Aboriginal and Torres Strait Islander peoples Delivering better health outcomes for remote and rural communities Supporting people living with mental illness Improving oral health and access to dental care
Driving quality performance	Strengthening the governance of health and health care Raising and spending money for health services Working for us: a sustainable health workforce for the future Fostering continuous learning in our health care system

Given the breadth of the Commission’s terms of reference, the College is in agreement with these key themes and has addressed many of these in earlier submissions.

In a very comprehensive report the Commission has used these themes as the basis for providing responses to the concerns of the health sector with regard to issues of governance, strategy and policy. These are summarised in the Report as Reform Directions under the following headings:

Building good health and wellbeing into our communities and our lives
Creating strong primary health care services for everyone
Nurturing a healthy start to life
Ensuring timely access and safe care in hospitals
Restoring people to better health and independent living
Increasing choice in aged care
Caring for people at the end of life
Closing the health gap for Aboriginal and Torres Strait Islander peoples
Delivering better health outcomes for remote and rural communities
Supporting people living with mental illness
Improving oral health and access to dental care
Strengthening the governance of health and health care
Raising and spending money for health services
Working for us: a sustainable health workforce for the future
Fostering continuous learning in our health care system

The Commission is to be congratulated for recognising and articulating the complexity of Australia's health network, the sectors that work well and the myriad of areas, interfaces and systems that need ongoing change, resourcing and improvement. The challenge now confronting the Commission is to produce a report that can ensure future improvement, not only in terms of direction and policy, but in terms of tangible benefits. This must be achieved in the face of considerable obstacles, including current and often unwieldy structures, the complexity of implementation and the lack of resources required to make changes.

In this response to the Commission's Interim Report, the College will address a number of issues within the recommendations which it feels warrant additional emphasis, or where it believes the detail of policy will be critical to achieving change of lasting benefit to the community.

Section 1 Building good health and wellbeing into our communities and our lives

The Commission highlighted a number of key areas in this section including the many factors that contribute to building healthier communities. Issues such as employment, education, housing, early childhood development as well as clean air, safe food and water contribute to our health. There is substantial emphasis on the role of health promotion and the importance of leadership at a national level. There is also a pressing need to build literacy in health and related areas.

The recommendations arising from this section that the College particularly supports include the recognition of the "wellness footprint of communities" and the way these interact with issues of urban planning, public transport, community connectedness and a sustainable environment. Health cannot be viewed as an isolated issue, and the delivery of effective health services is linked to all-of-government policies affecting communities and their critical infrastructure.

While rolling ten year goals of improved community health are laudable, they must go beyond health promotion and preventative strategies to an orchestrated combination of expectations, responsibility, and program identification and delivery. And this must involve individuals, communities and governments.

The College's previous submissions highlighted the importance of prevention and promotion programs that are efficacious and cost effective. These are the programs that need to be incorporated into the health literacy initiatives.

Section 2 Creating strong primary health care services for everyone

The College strongly agrees with the Commission's conclusion that primary health care services need to be strengthened. While primary care can become more comprehensive, it needs to be delivered within a team-based environment. The College can authoritatively assert that team-based care at the primary, secondary and tertiary levels, with the clear delegation of tasks and recognised lines of responsibility, provides better co-ordinated and more reliable patient care than the alternative models that are sometimes proposed. Chronic care must also be team-based, with clear lines of support into the community.

The lack of value attached to primary care has led to inadequate clinical services outside of routine office hours. Consequently residential care services for the aged and after-hours services frequently default to Hospital Emergency departments for clinical care. It is well documented that this produces inappropriate hospital admissions, the prolongation and worsening of morbidity, and patient dislocation.

The College strongly supports the rationalisation of funding. Our preferred model is that one authority be responsible for the funding of the entire health sector. If this is not achievable, then there needs to be clear delineation between funding responsibility for the various types of care (i.e. hospitals, aged care and primary care). The College strongly supports the Commonwealth having responsibility for all primary health care.

The College also supports the introduction of a reliable patient-held electronic clinical record that can be used not only in primary care but across the entire health sector.

Section 3 Nurturing a healthy start to life

The College strongly supports a commitment to early childhood development initiatives. Health is linked to strategies and policies across all areas of society and this is particularly so in the case of childhood development. The College echoes concerns about access to a system of paediatric care which balances the trend towards specialisation and the centralisation of services with high quality paediatric care. Much can be done to foster outreach services, and the ongoing professional development of paediatric surgeons, ensuring there is a workforce capable of meeting the surgical challenges related to childhood health problems. Initiatives need to be identified which enhance access to both local and outreach services in regional and rural areas. This is particularly so in the case of complex or chronic care.

Section 4 Ensuring timely access and safe care in hospitals

The College acknowledges the Commission's finding that, by international standards, Australia's public and private hospitals provide high quality care for most people most of the time. However, due to the complexity of our systems, political considerations that distort the priorities for hospitals, and now chronic under-resourcing, our international standing is at risk. Given that issues of generational change now confront the health sector, the vulnerability of a system relying on the professionalism and diligence of overworked staff is substantial.

The demands of patient care are simply overwhelming. There is a growing international literature indicating that hospitals should operate at 85% of bed capacity for reasons of efficiency and safety. Few public hospitals in Australia would have spare beds to this extent, and this is a key driver behind inappropriate measures of access to care for both emergency and non-urgent cases. The word "elective", as distinct from non-urgent, became a misnomer in the public hospital sector about a decade ago.

Just as there is no focused "ownership" of Australia's health in the political context, there is no focused "ownership" of the health sector. Political processes concentrate on either the public or private sectors. Efficiencies in one sector are not achieved to help improve the other, but rather are driven by its own budget imperatives. The Federal system looks within certain parameters while the States focus only on areas in receipt of direct funding. The fact that issues of patient safety may arise in private hospitals does not seem to concern the State Health Minister who is preoccupied monitoring public hospitals. Concerns are not addressed in a comprehensive and coherent manner, and the State-based Departments of Health are at best ignorant of, and at worst hostile to, activities in the private sector – even when they occur in co-located public private organisations. There is no political or senior departmental leadership, and even co-operative bodies such as the Australian Health Ministers or the Australian Health Ministers Advisory Committee have no effective "all of system" approach to the health sector. With responsibility for healthcare and funding so divided, it is little wonder that one level of government is quick to blame the other when the system fails its patients.

The College supports the national collection of access data but notes ongoing concerns about the distortions produced by measuring only one component of a complex system. Changing waiting list categories/measures to only coronary artery surgery or cancer treatment will immediately ration other types of procedures on waiting lists. If incentive payments which are usually a percentage of an already insufficient budget are allocated to these, then managerial "adjustments" are foregone conclusions. Very careful changes to the system of data production and collection are required and this process must fully involve clinicians.

There is no doubt the development of case-mix funding and payment on outputs has facilitated the understanding of costs and the introduction of efficiencies. However, after

almost twenty years the models in place in Australia are a complicated arrangement of allocated core funding and “band-aid” payments, accounting for a policy that has not adequately recognised or funded areas such as dialysis and oncology. Nor has it properly supported the complexity of major teaching hospitals and their commitment to teaching and research. Although surgeons strongly support output focused funding, the models have been subject to budget reductions that have produced substantial irregularities.

Clinical leadership and clinician involvement in the direction and management of hospitals is critical for the best outcomes. Where local management actively involves clinicians, services have continued to remain patient focused and have provided balance within an underfunded and politically/bureaucratically driven structure. The College strongly supports governance and management structures based wherever possible on individual hospital structures.

Measures on access, efficiency and quality of care are important. However issues of comparability and risk adjustment remain critical. The College continues to advocate for local peer based review and audit. The College receives funding from various States to fund the Audits of Surgical Mortality. A combination of essential local audit into specific morbidity measures and state-wide review of mortality are a fundamental component of a “platform of safety”. The College has concerns about many of the measures currently proposed that are based on administrative systems with limited clinician input.

The College believes that the models for the provision of trauma/acute and elective surgery need ongoing revision. Trauma centres are a specific requirement and need to have a centralisation of 24 hour sub-specialty expertise. The College has recently been involved with trials of different approaches to the delivery of acute surgery services. Although this will always depend on local circumstances, the appropriate rostering of surgeons to ensure on-site commitment has enhanced efficiency and produced improved outcomes in the hospitals where this has been trialled. Equally, there is now a strong case to be made for formally separate elective surgery facilities, so that competition for staff, bed and operating theatre resources does not compromise patient care. Both of these models can be used with benefit in the ongoing education and training of surgeons.

Section 5 Restoring people to better health and independent living and
Section 6 Increasing choice in aged care

The health sector needs to appropriately recognise and better resource the sub-acute area. For too long funding has been inadequate or “appropriated” from acute services. This has been to the detriment of the entire sector because patients have not been able to access rehabilitation or community based services in a timely and effective manner. When interface communication or transfers fail, the patient inevitably returns to the acute sector, producing excessive demand for limited hospital beds.

The College reiterates that this funding should not be to the detriment of the acute sector. Proper and additional funding needs to be allocated.

Workforce issues are critical in this sector. As an example the shortage of nursing staff is significant in all sectors, producing inefficiencies and dangerous practices. However this is at crisis level in the aged care sector, with subsequent degradation of care. The ongoing sanctioning of aged care facilities is just some of the evidence of this loss of standards.

The demands of aged care will change the demands on surgical services. The increased requirements for surgical intervention in chronic and degenerative diseases, combined with the increased aging and retirement of the current surgical workforce, highlights the requirement for more training opportunities. The College has been actively engaging with all State governments to provide ongoing quality training positions. These need to be supported by surgical activity and infrastructure in both the public and private sectors. Some initial improvements have occurred, but with the doubling of medical graduates from 2004 to 2012 it is vital to ensure ongoing training opportunities are available.

Section 7 Caring for people at the end of life

The College strongly supports advanced care planning. There have been substantial changes in expectations with regard to the clinical care being made available to the elderly. On the individual basis this may be understandable, but does not speak to the appropriateness of that care. Futile surgery is a devastating outcome for the patient, family and clinicians. Days, weeks or months of intensive hospital care culminating in death needs to be questioned. And it needs to be questioned while the patient is able to contribute to the discussion. The College believes there are grounds for “compulsory” recording of advanced care planning in the admission of all residents in aged care facilities. The wishes of these people need to be understood and respected.

Section 8 Closing the health gap for Aboriginal and Torres Strait Islander peoples

The College agrees that a whole of government approach is required to address the social determinants of health and the improvement of health services. Much of this is focused on the management of chronic disease. The College is keen to participate in initiatives and is already involved with a number of peak groups. The College wants to see a higher number of Aboriginal and Torres Strait Islanders contemplating and completing the training required to become a surgeon. The College would like to work with the appropriate bodies and groups to help achieve this.

The College already works closely with Maori groups to promote appropriate cultural understanding in New Zealand and would like to see comparable initiatives in Australia.

Section 9 Delivering better health outcomes for remote and rural communities

Providing health services in remote and rural communities needs an all of government approach. Australia is one of the most urbanised countries in the world and regional infrastructure has suffered substantially in comparison to city based investment.

Health services no longer involve a “single practitioner” but a complex system requiring expensive infrastructure and a range of health professionals demanding a meaningful work/life balance. This does not occur within a single provider model. Most surgeons would now prefer to share on-call work and this is most effectively delivered by a group of at least four surgeons. The population required to support four surgeons, working in a properly resourced hospital with related services, needs to be substantial. Moreover this team of surgeons, and the other health professionals working alongside them, have families that need to build meaningful lives in the region. So the health service exists in the context of regional services. Government must address regional policy, if a sustainable regional health policy is to follow.

The various specialties need to address issues of broader training and experience at a time when there is a pronounced trend towards specialisation. “Generalisation” is of pressing importance across all the health professions if adequate regional services are to be provided. This is both a training and experience issue. The attractiveness of these careers is also crucial. The appeal of a regional lifestyle is substantial but is only part of the answer. If the health related professions in regional and rural areas are to be valued, working conditions and remuneration need to be competitive; this is especially so given the considerable after hours and generalist work involved.

At the same time the College is a keen supporter of outreach services and, as appropriate, tele-health. The Fellows of the College are involved in a number of innovative models where services are provided to smaller towns and regional centres. However, there needs to be political and departmental commitment to multi-year solutions if these are to be sustainable.

It should also be noted that the trend away from “general” surgery is partly attributable to the increasingly litigious nature of the Australian medico-legal environment. This major disincentive to generalist work is having an adverse, if indirect, impact on regional and rural services.

Section 10 Supporting people living with mental illness

The College agrees that mental illness requires a comprehensive approach that properly supports provision of care in the community. The de-institutionalisation of mental health was one of the more significant initiatives twenty years ago. Now, due to ongoing underfunding and a lack of understanding of how acute and residential services need to be provided, there are too frequently crises and clinical tragedies. A systemic approach is required to minimise these.

Section 11 Improving oral health and access to dental care

The lack of proper dental care is a substantial concern. It is a vital component of a person's well being. While the College is not in a position to evaluate the proposed funding model, it is highly supportive of proposed improvements in this area.

Section 12 Strengthening the governance of health and health care

The College strongly supports the principle of a single funding authority for the health sector, believing it to be the only model that can substantially address the "blame game" and reduce the cost shifting that occurs. Significantly, there is no one body or group that has responsibility for the health of the Australian community. Even the most senior officials and politicians are captives of a fragmented system they are supposed to manage. To have a State Health Minister responsible for only a fraction of clinical care in that State, and unable to take advantage of the benefits of working collaboratively with both the public and private sectors, must inevitably lead to frustration on the part of taxpayers. Even if members of the public have the persistence to be heard, they may often be advocating to a group that is not responsible for the given problem or may not have the organisational capacity and resources to improve the situation.

The College believes that a single funder model will simplify matters and at least ensure greater accountability. If that proves to be politically unachievable then the delineation of responsibility needs to achieve minimal crossover points. Efficiencies for the whole system need to be prioritised and delivered. Spending less on aged care or residential care does not lead to more efficient hospitals. Not providing incentives for the provision of medical care after hours or within aged care facilities does not decrease the global health budget. It produces expensive use of the hospital system and futile care. Bringing the funding together would facilitate overall improvements and accountability for the care of the patients.

The College agrees that a single government, and most obviously the Commonwealth Government, should be providing leadership in patient safety and quality, health promotion and prevention, professional registration, workforce planning and education, performance reporting, private hospital regulation and technology assessment. However there is currently limited if any leadership. Despite the work of a number of bodies, and the outstanding contribution of a number of individuals, the governance model of reporting to an aggregated set of Health Ministers is profoundly flawed. Driven by different electoral cycles, differing political pressures and the ongoing replacement of senior staff, the decision making process is opaque, and responsibility/accountability for implementation across the sector made problematic. The current governance model must change.

The College supports the view that the Commonwealth should be solely responsible for all aspects of health care, delivered through regional health authorities. These regional health authorities should be responsible to their communities for the delivery of health services according to the quality and financial measures that are agreed between the community and the Commonwealth. A local Board should be held accountable for this and these Boards need to include community members and Commonwealth Funder representatives, with strong input from health service providers.

Section 13 Raising and spending money for health services

The College supports the ongoing contribution by the private and public sectors to the delivery of health services. No system is perfect but this appears to provide universal health care while also enabling people to source more timely services or a differing array of services. It is important that key services like dental care are more fully covered under the universal health care model. A better system of safety nets would support equitable access to health services.

Despite spending 9.0% of GDP on health, rationing of health care does occur in Australia. It is important that there be open debate about what is provided and funded service. By ensuring prioritisation of clinical services occurs, a rational approach to the global funding requirements may be achieved.

The College supports cost effective delivery of health services. The models of activity based funding, payments for disease types and payments for higher levels of performance have much to be admired. However the difficulty in Australia has been that these measures have been introduced during a period of budget restrictions and an absolute reduction in available spending. To enable these funding models to be effectively introduced they need to be carefully transitioned, and this may require some additional transitional funding.

Allocation of capital does not reflect rational service driven requirements but the political drivers of the day. Capital infrastructure is comparatively starved, particularly in the public sector. It needs to be factored into the service payments for delivery of the clinical services.

Section 14 Working for us: a sustainable health workforce for the future

The College supports the assessment of the Commission that the dedication, diversity and dynamism of our health workforce are major strengths of the Australian health system. They should be a source of pride to the community, the various health departments and our political representatives. They are also supported by a substantial group of volunteers who undertake many roles, particularly that of informal carers.

One of the most ill advised policies of the last 30 years was the curtailment of medical school intakes and graduations, with subsequent specialist training being limited. Despite decades of representation it has only been acknowledged as a workforce crisis in the last five years. Graduate numbers are now increasing but governments are still largely ignoring the requirements for substantially more training positions for specialist staff. Much more needs to be achieved through cohesive programs that highlight regional opportunities, private sector opportunities and the continuation of the public hospital training tradition. This needs support in terms of clinical activity to provide the training environment, infrastructure and recognition of the numerous trainers/supervisors that are now expected to pick up a greater workload in a regulated and demanding system.

The workforce crisis in the medical area may be less significant than in other health professions such as nursing. The efficiency of hospitals is substantially reduced by the lack of skilled nurses in the wards, intensive care and operating theatres. Substantial inefficiencies are confronted when access to beds, operating theatres or operating times are not achieved due to staffing shortages. However the provision of nurses in the hospital sector is at a higher level than in the aged care, residential or mental health sectors. The crisis in workforce numbers is particularly affecting the nursing health profession, and the government must address this.

In a world where there is an absolute shortage of health professionals the importance of clinical teams becomes paramount. Surgeons have worked within these teams with clearly delegated and designated tasks for many years and are comfortable with these models. Surgeons have strongly supported the development of additional expertise for groups like breast cancer nurses, physician assistants and practice nurses who can undertake much of the administrative and other functions that are increasing in the health sector at an exponential rate. With the shortage of health professionals the College remains highly

sceptical of the substitution model that is variably proposed. Experience with this overseas demonstrates fewer clinical treatments and concerns about safety and standards.

The College supports the improvement of workplace culture. The health sector is variously acknowledged as an often hostile or uncaring workplace. Bullying, harassment and intimidation are common. The response to this needs to be comprehensive and sector-wide. The College of Surgeons has recently commenced an intensive educational and awareness campaign to start addressing this. The College is establishing an Academy of Surgical Educators with one of its prime purposes being to provide higher levels of professional development, particularly over such issues as assessment, providing feedback to trainees and creating a supportive work environment. However this needs to be incorporated into regular reviews and systems in the workplace if it is to become all encompassing. This is an example of how leadership on this issue can be demonstrated.

The Australian Medical Council accredits the Education and Training program of the College of Surgeons. Competency based standards and curricula have evolved over the last 10 years utilising as a framework the CanMEDS model. Although a supporter of this framework to provide greater understanding of the breadth of training, the College highlights the increasing importance being placed on professional issues. This has been significantly canvassed in international educational literature, where the “atomisation” of a vocation has removed the reason why it is a vocation. There is no doubt that skills need to be learnt and mastered. However this is where the “whole” of a professional is vastly more than just the aggregate of the delineated individual components. The College will be progressively moving beyond the sole use of competencies. They are important but the College of Surgeons, and indeed the training bodies of all health professionals, train for much more than just competence. They train for the high level performance of a talented professional. The College will continue to view with respect, but some scepticism, the competency model as it is currently being grasped by workforce officials of the various Departments of Health. It remains only part of the solution to the educational requirements of a professional and only part of the understanding of workforce shortages.

The College believes that there needs to be far greater cohesion between the education and health sectors in ensuring workforce requirements are met. Medical intakes are usually competitively filled and attrition rates are small. The university based undergraduate or graduate courses appear to be well constructed and certainly rigorously assessed by the Australian Medical Council. The post graduate specialist medical training programs are also accredited by the Australian Medical Council and many Colleges now partner with a number of universities and State based training networks to ensure a comprehensive range of training opportunities are available to trainees. However in the nursing area there are yearly sagas of mismatch between intake, program availability and clinical placements. Attrition rates remain high. The College of Surgeons does not pretend to be an expert in providing nursing education. However as the most substantial shortfall in the workforce is within the nursing profession, the ambitions of the health and educational sectors must be aligned more effectively. The College remains unconvinced that a Clinical Training Agency can be the vehicle to improve this. The introduction of the PMETB processes, combined with the Modernising Medicine agenda in United Kingdom, has not been productive. Substantial unrest, external reviews and disaffected health professionals resulted. The College of Surgeons will not be supportive of a National Clinical Education and Training Agency without having substantial detail made available. The interconnections across the health sector in a training period that may exceed fifteen years is likened to a coral reef – seemingly strong but also incredibly fragile. It is also easily destroyed.

The College has already indicated that the responses to workforce shortages in regional and rural areas requires a comprehensive approach to improving infrastructure, ensuring critical mass is achieved and making the provision of these services more attractive. Having an army of partially trained “barefoot doctors” is not an appropriate model for Australia.

The College remains committed to the concept of an appropriate model for national registration. However, the current proposal from Australian Health Ministers inappropriately

combines this initiative with accreditation. Unfortunately, the COAG initiatives fail to reflect these different requirements and responsibilities.

There are some benefits in having national registration. However it needs to be quite separate from accreditation and the establishment of the standards required to become a health professional. It also needs an accountable and responsible body – not the ill defined Australian Health Ministers – to oversight these processes if it is to be successful.

Section 15 Fostering continuous learning in our health care system

Health and medical research has an excellent reputation in Australia and is justifiably acknowledged as “fighting above its weight”. However, clinically based research continues to stay the underfunded “poor cousin” of the more “scientific” bio-medical research. Even bio-medical research is substantially underfunded and is often squeezed out by service demands.

The College strongly believes that health systems need to be more fully researched and the improvements in the system made available in a broad and comprehensive way. Combining this with active leadership and a commitment to safe, high quality and effective health care could produce tangible benefits.

Commitment of resources to the health sector in terms of infrastructure are important. Bodies such as NHMRC, NICS and the Safety and Quality Commission already exist. However their remit needs to be broadened and enshrined in more definite ways. Without the certainty of the existence of these bodies, ongoing improvements to the system will remain fragile and patchy.

By ensuring these bodies can work effectively with groups like AIHW, the gathering of sensible performance and quality related data can be ensured and broadly promulgated across the sector. Hopefully improvements in quality and systems can then be achieved and more equitably shared across Australian society.