Australian Federal Election **Statement 2022**

Eleven ways the next Australian Government can protect and improve health outcomes

In Australia we can be thankful that ours is among the best healthcare systems in the world. In the financial year immediately 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.

Nevertheless, with the pandemic ongoing, in an environment of global instability and increased calls on the federal budget, there are many policy issues which the next Australian Government must face if health outcomes for Australians are to be maintained and improved.

If there is one thing the pandemic has taught us, it is that poor health outcomes lead to negative economic and societal outcomes.

This election RACS is calling for the next Australian Government to put politics aside and demonstrate a genuine commitment to health by:

1. **Building respectful and safe workplaces for all who work in surgery and the wider health sector**
2. **Guaranteeing the public sector provides timely access to essential surgery**
3. **Expanding surgical (and other specialist) services in rural areas**
4. **Expanding surgical (and other specialist) services for Aboriginal and Torres Strait Islander people**
5. **Protecting the public by restricting the title 'surgeon' to those with accredited advanced surgical training**
6. **Improving care through appropriate clinician-led patient outcome data collection and dissemination to clinicians, understanding the many unintended consequences of non-risk adjusted release to the public**
7. **Ensuring the Medicare Benefit Schedule provides equitable access to health services and remains contemporary**
8. **Preventing incremental moves to US-style 'managed care' and ensuring our mixed healthcare system continues to thrive**
9. **Reducing death and serious injury on our roads**
10. **Safeguarding the health of all Australians from the threat of climate change**
11. **Committing to health security and long-term health systems strengthening in the Pacific**

For each of these issues RACS has provided its view on the specific actions the next Australian Government should take.

The Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons (RACS) was established in 1927 and is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand and Australia.

RACS supports the ongoing development, maintenance of expertise and lifelong learning that accompanies the surgical practice of more than 8000 surgeons and 1,300 surgical Trainees and Specialist International Medical Graduates.

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves and, as part of this commitment, strives to take informed and principled positions on issues of public health.

Building respectful and safe workplaces for all who work in surgery and the wider health sector

It is RACS' position that the next Australian Government should:

- Work with state and territory governments, as well as health workforce stakeholders such as medical colleges, on the development of policies, programs and processes to deal with discrimination, bullying and sexual harassment in surgery and the wider health sector.
- Work to implement the full suite of recommendations contained in the Australian Human Rights Commission Respect@Work report, including legislation to place a positive duty on employers to prevent sexual harassment at work.

Building Respect, Improving Patient Safety

A 2015 report commissioned by RACS found that nearly half of all surgeons across all specialities had experienced discrimination, bullying or sexual harassment. Both male and female Fellows, Trainees, and Specialist International Medical Graduates had been the subject of such behaviour. These issues are not just about workplace safety for surgeons and other health sector employees. A substantial body of international evidence has been established linking unprofessional conduct in the health sector with increased risks to patient safety.

Spurred to action by this report, in the years since RACS has implemented a *Building Respect, Improving Patient Safety* initiative to address these issues. A report on the initiative in early 2022 found that six years' work has built awareness and understanding of the need for surgeons to operate with respect. But there is still much work to be done to foster professional behaviour that keeps teams performing at their best and patients safe in health settings across Australia. In some areas, work has only just begun and in others, entrenched problems will be solved only by cross sectoral commitment and collaboration.

RACS is thus keen to work with state and territory governments, as well as health workforce stakeholders to push forward this important work.

Respect@Work report

With the College's firm focus on the issue RACS contributed to the Australian Human Rights Commission's Respect@Work inquiry in 2020.

RACS strongly supports the recommendations contained in the final report including with regards to its recommendation for legislation which would place a positive duty on employers to prevent sexual harassment at work.

Guaranteeing the public sector provides timely access to essential surgery

It is RACS' position that the next Australian Government should:

- Work with state and territory governments on a national plan to address the growing and increasingly critical backlog of elective surgeries.
- Work with state and territory governments on a review of the national definitions for elective surgery urgency categories. This review should also consider the numerical terminology used to define elective surgery (cat. 1, cat. 2, cat. 3), as well as the term 'elective surgery' itself.

Patients waiting longer for procedures

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 per cent to 32 per cent, in just the last two years. For many patients waiting in line to have a critical operation, in pain, the delays in having surgery can be devastating.

A national plan needed for elective surgery

RACS has supported the postponement of elective surgeries to accommodate COVID-19 affected patients in hospitals. We understand that different lockdowns have different purposes. In 2020, the concern was a lack of Personal Protective Equipment (PPE). In 2021, it was more about containing the spread of the virus. However, two years into the pandemic and with a highly vaccinated population, blanket suspensions of elective surgery should only be used as a last resort.

A more nuanced approach to management of surgery lists is now warranted. We must also ensure that however the process is negotiated with surgeons and RACS, surgical Trainees continue to gain appropriate experience in all competencies and that appropriate surgical standards remain.

A plan is needed to restore reasonable and acceptable access to elective surgery, as well as a long- term funding arrangement to ensure the backlog is cleared. One-off funding packages and elective surgery blitzes will not be enough to address the impact that the last two years have had on the already stressed health system and its capacity to deliver care for patients into the future.

A review of elective surgery urgency categories, and the term 'elective surgery'

During the pandemic the categorisation of elective procedures has assumed more importance than ever before, with a particular categorisation often converting to a blanket ban, rather than an expected waiting period, and with the system expanded to cover private procedures.

The system as used has not delivered fair and consistent outcomes for patients and clinicians as procedures have not always been categorised consistently.

The view that certain procedures are not 'urgent' based on the fact that they may be 'category 2' or 'category 3' has caused immense frustration amongst patients and doctors and impacted on clinical outcomes.

An elective procedure is not an optional procedure that a patient elects to have or a doctor elects to deliver – it is essential surgery. It is surgery to address often life-threatening conditions and conditions that prevent patients from living a normal life because of severe pain or dysfunction.

A review should be undertaken of national definitions for elective surgery urgency categories, whether the numerical system is appropriate, and of the appropriateness of the use of the term 'elective surgery' itself, particularly in light of experiences during the pandemic.

The sector must be careful that the terminology used to define types of surgery does not result in the importance of these procedures being diminished, or be used to implicitly justify long waiting times.

Expanding surgical (and other specialist) services in rural areas

It is RACS' position that the next Australian Government should:

- Establish a Federal mechanism tasked with addressing barriers to surgeons practising in rural areas and implement changes to address these barriers.
- Maintain *Flexible Approach to Training in Expanded Settings (FATES)* funding for an initial 5 year period.

A lack of access to surgical and other specialist medical services in rural areas

People living in rural, regional and remote locations have worse health outcomes, compared with people living in metropolitan areas. RACS acknowledges the government's commitment to rural health including under the recently launched National Medical Workforce Strategy (NMWS), and in particular the government's emphasis on the need for rural generalists. RACS fully supports this focus on rural generalists, but also believes that there needs to be an increased focus on access to specialist services and, in particular, surgery in rural areas. Rural communities need specialist services delivered to them.

At present approximately 29 per cent of Australians live in rural and remote locations. But according to RACS census findings only 12 per cent of RACS Fellows (FRACS) live and work rurally in Australia and for five of the nine surgical specialties, less than 5 per cent of surgeons were based outside cities.

The reasons for this maldistribution are multifaceted. RACS has acknowledged that some of RACS' own policies and systems are barriers, for example in relation to selection of trainees. RACS is addressing these barriers under the RACS Rural Health Equity Strategy, adopted in 2020.

A mechanism to identify and bring down barriers, and recommend appropriate funding models

There are however other barriers which only government can address. RACS' position is that as the NMWS is implemented, a long-term mechanism must be put in place to address the specific barriers to attracting and retaining surgical trainees and surgeons in rural areas. Some barriers to being based in rural areas may be faced by all doctors, for example a lack of reserved day-care and school positions, others such as unsafe on-call rostering hours may be a particularly important issue for surgeons and other specialists.

This surgery/specialist focused mechanism should make policy recommendations and implement them to address these barriers. One often cited idea is flexible contracts allowing surgeons to more easily move between rural and metropolitan areas.

Policy recommendations must include funding models to provision rural areas with the infrastructure and supporting personnel requirements to deliver safe surgical/specialist care.

Such a mechanism would leverage the Flexible Approach to Training in Expanded Settings (FATES) program. Having only commenced in 2021, it has yet to bear fruit, but RACS is a strong supporter of FATES, as an innovative funding model with the potential to bring more specialists to regional areas, and ensure all Australians can access high-quality care.

Expanding surgical (and other specialist) services for Aboriginal and Torres Strait Islander people

It is RACS' position that the next Australian Government should:

- Establish a Federal mechanism tasked with achieving equitable and safe surgical and other specialist services for Aboriginal and Torres Strait Islander People, across Australia.
- Consider, support and implement innovative pathways for Aboriginal and Torres Strait Islander people to access surgeons and other specialists.

A lack of access to surgical and other specialist medical services, particularly in rural areas

Aboriginal and Torres Strait Islander people continue to have worse health outcomes compared with other Australians. RACS acknowledges the major parties' commitment to Indigenous health and applauds efforts in bolstering primary health care. However, RACS' position is that there needs to be an increased focus on access to specialist services and pathways to get well.

Geographical maldistribution of specialist services is a significant factor contributing to poorer health outcomes among Aboriginal and Torres Strait Islander people.

A mechanism to identify and bring down barriers, and develop appropriate funding models

RACS advocates the establishment of a federal mechanism which will address barriers to Aboriginal and Torres Strait Islander people accessing surgical and other forms of specialist healthcare. As an element in this the mechanism should support policies to attract and retain surgical trainees and surgeons, particularly Indigenous surgeons, working on health issues more common in Indigenous communities, and which improve the maldistribution of the workforce.

As well as identifying barriers to access and to surgeons working on relevant health issues in relevant geographic locations, the mechanism must be tasked with designing and implementing funding models which provision Aboriginal and Torres Strait Islander care with the infrastructure and supporting personnel requirements to deliver safe surgical care.

Models of care that enhance primary health care and specialist outreach services to the community, by the community and for the community are vital.

Protecting the public by restricting the title 'surgeon' to those with accredited advanced surgical training

It is RACS' position that the next Australian Government should:

- Support the restriction of the title 'surgeon' to those with accredited, advanced surgical training under the Health Practitioner Regulation National Law.*

*RACS' detailed position on this issue is outlined in its submission to the Health Council Regulation Impact Statement Consultation on use of the title 'surgeon'. Please email RACS.advocacy@surgeons.org to receive a copy.

Reports of adverse outcomes when surgery is performed by non-specialists

Although under the Health Practitioner Regulation National Law many medical specialty titles are restricted, use of the title 'surgeon' is not. This means that those who have not undertaken accredited specialist training in surgery can advertise themselves using terms such as 'cosmetic surgeon'.

RACS is concerned about reports of patients suffering adverse outcomes when elective, cosmetic surgery is performed by medical practitioners advertising themselves as cosmetic surgeons, but who do not have specialist registration in a surgical discipline.

The Health Council's consideration of use of the title 'surgeon'

RACS welcomes the Health Council's consideration of options for reform of the regulation of the title 'surgeon', as described in a Consultation Regulation Impact Statement released in December 2021.

With the focus squarely on patient safety, RACS' considered position is that only those registered in specialties for which the relevant Australian Medical Council (AMC) accredited training program includes a significant surgical component at a sufficient standard, should be able to use 'surgeon' in their titles.

This is not about 'protecting the turf' of RACS' Fellows. Under RACS's position, medical practitioners who have completed accredited surgical training of a sufficient standard but who are not RACS Fellows would be able to use the term 'surgeon'.

Protecting the public, and maintaining public confidence in our health system

Australians rightly expect all surgical procedures to be performed to the highest possible standards. They expect those carrying out procedures to meet nationally established educational standards, undertake regular training and be registered in an appropriate specialty.

Restricting the title in the way RACS proposes would meet the Australian public's expectations and guarantee that people advertising themselves using 'surgeon' in their titles have the necessary physiological, ethical, psychological, pharmacological and medical training and experience to safely diagnose, treat and manage surgical patients.

Those who are not trained to the standard which RACS advocates do not necessarily have this guarantee.

Restricting who can use 'surgeon' in this way would help prevent patients from undergoing surgery under an incorrect assumption about the quality and standard of training of the person carrying out the surgery. It would also help maintain public confidence in the high standards of our health system.

Improving care through appropriate clinician-led patient outcome data collection and dissemination to clinicians, understanding the many unintended consequences of non-risk adjusted release to the public

It is RACS' position that the next Australian Government should:

- Work with and be guided by RACS and other medical associations on an appropriate model for the collection, collation and publication via registries of patient surgical outcomes data.
- As necessary, work with states and territories on an appropriate legislative and administrative framework for the patient surgical outcome registries model as co-developed.
- Provide appropriate funding for the patient surgical outcome registries model as co- developed.

RACS is supportive of appropriately designed and used patient outcomes registries

RACS is very supportive of increased transparency in relation to surgical performance, quality and outcomes. RACS' position is that appropriately designed and used patient outcomes registries can be very valuable in driving improvements in the care provided by individual clinicians and hospitals, as well as the health system as a whole.

Useful registries are very complex and expensive to set up

However useful registries are very complex to set up, often because useful outcomes metrics are difficult to identify, but also because of the fragmented nature of Australia's health system, and because registries become expensive to administer.

Useful data is often not actually collected in a systematic sector-wide way. Data collected regarding particular procedures varies greatly across hospitals and health systems and may be held by a variety of different stakeholders, such as private health insurers. To ensure that 'rubbish data-in' does not result in 'rubbish data-out', in most cases new data collection systems would need to be set up. These would need to be funded. Different jurisdictions and hospital systems will have different data collection rules to be dealt with.

Poorly designed & used patient outcome registries have great potential for perverse consequences

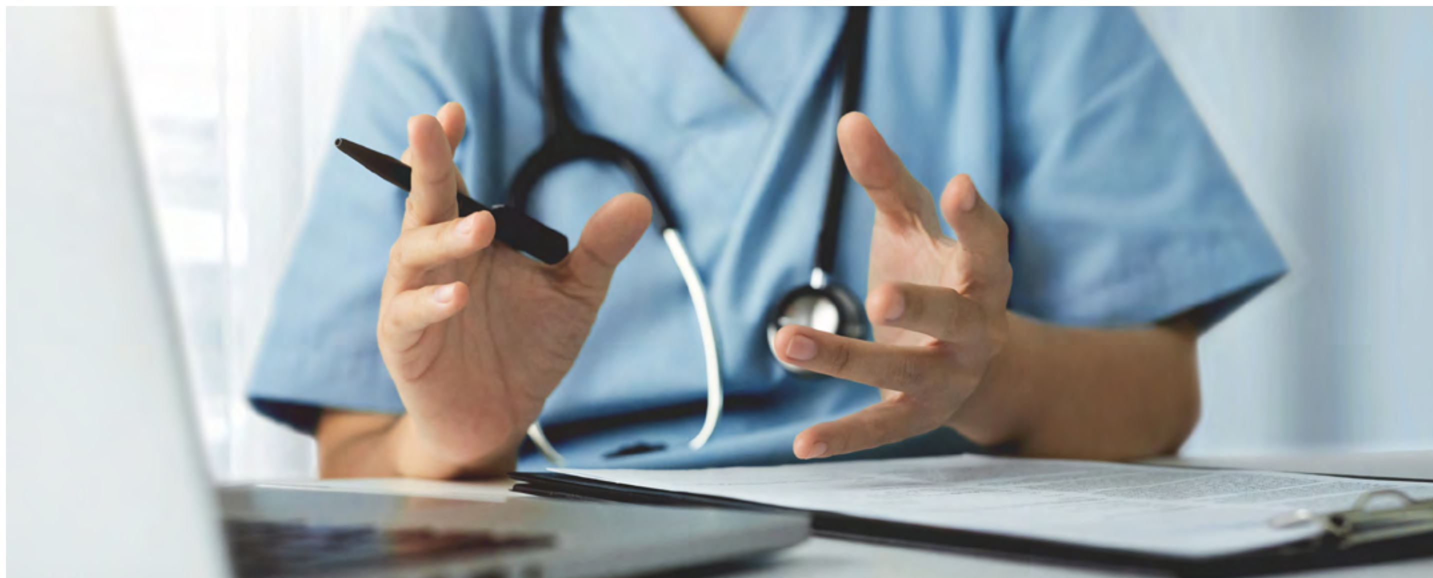
If poorly communicated and if not put into relevant context, outcomes measures may tell an entirely incorrect and unfair story about healthcare providers. For example, highly skilled healthcare providers, who because of their skill take on complex cases may have worse overall outcomes than other providers who undertake less complex procedures.

If rankings on outcome metrics come to be decisive in choices about which healthcare providers are used, it may have the perverse impact that providers will refuse to do particularly complex procedures because of the possibility that doing so may have a negative impact on their ranking. This is likely to be particularly the case were private health insurers to implement 'managed care' where outcomes metrics are used to 'punish' providers, as is the case in jurisdictions aboard.

RACS is concerned that poorly designed and communicated metrics may cause prejudice against rural hospitals in favour of large metropolitan hospitals and have the perverse impact of undermining efforts to build health access in rural areas.

It also needs to be acknowledged that sometimes the benefits of surgery are not easily quantifiable. Some particular surgical procedures have basic binary metrics for success or failure, such as is the case with IVF. However, this is often not the case, with the benefits of surgery often being somewhat difficult to measure. This is particularly the case for surgery with the aim of improving for patients with chronic ailments.

Despite the complexities in setting up useful registries and concerns about unintended consequences RACS' position is that appropriately designed and used patient outcomes registers can be a valuable tool for improving patient care, and RACS would be keen to work with a future government on the concept.



Ensuring the Medicare Benefit Schedule provides equitable access to health services and remains contemporary

It is RACS' position that the next Australian Government should:

- Ensure that all Australians have appropriate access to specialist telehealth from the initial consultation.
- Consult closely with RACS and other peak medical groups on the Medicare Benefits Schedule continuous review.

Changes to telehealth arrangement needed to ensure equitable access

RACS welcomed the government's announcement of 'permanent telehealth' in December 2021. The government's decision in early 2020 to introduce temporary telehealth Medicare Benefits Schedule (MBS) item numbers was invaluable during the pandemic and demonstrated the role telehealth can play in the Australian health system over the long term.

However, RACS does not support the government's decision to restrict access to telehealth in certain circumstances. Specifically, in relation to specialists, RACS' position is that restricting the availability of telephone telehealth to subsequent, rather than initial attendances will create significant inequities among patients, with particular impact on those who would benefit most from telehealth. Among those who benefit most from telehealth include rural patients, the elderly, and hard-to-reach groups such as Aboriginal and Torres Strait Islander patients. However, it is these groups who are less likely to be able to access video telehealth. Elderly patients are more likely to struggle with new technologies, and rural areas are more likely to have bandwidth issues.

Clinicians must take a lead role to ensure the MBS remains up to date

RACS welcomed the Government's announcement of a Medicare Benefits Schedule continuous review process to ensure the Medicare Benefits Schedule remains contemporary and provides universal access to the best technologies and services. The massive undertaking of the 2015 – 2020 MBS Review, considering more than 5,700 items to update the MBS to reflect current medical practices, deliver greater consistency and clarity, and promote better use of data and evidence showed the value of an ongoing, rather than occasional, review process.

To ensure appropriate clinical expertise and buy-in, clinicians with relevant expertise must play central roles in all aspects of the continuous review. RACS is an appropriate first consultation point regarding surgical clinical feedback and recommendations for membership of the MBS Review Advisory Committee (MRAC)and clinical committees. Other medical colleges and medical groups should play roles in the review relevant to their clinical expertise.

Preventing incremental moves to US-style 'managed care' and ensuring our mixed healthcare system continues to thrive

It is RACS' position that the next Australian Government should:

- Ensure Australians are not subject to a system which restricts choice of medical practitioners or hospitals.
- Convene key stakeholders in the private health sector in a forum tasked with developing a comprehensive approach to addressing falling private health insurance membership.

A system in trouble

Australia's unique health system, with universal public access supported by a strong private sector which alleviates pressure on public waiting lists has made our health system one of the best in the world. However, it is widely acknowledged this system is in trouble with private health insurance rates in a long-term downward trend, particularly amongst the young. At the same time, especially in the context of the pandemic, public waiting lists are blowing out.

Concerns about moves towards US-style managed care

RACS is concerned that some believe that moving toward a US-style 'managed care' private health system is an answer to these problems. Under managed care a network of healthcare providers including surgeons are selected by an entity such as private insurer or buying group, restricting patient and doctor choices about providers.

In 2021 RACS opposed the application to the Australian Competition and Consumer Commission (ACCC) made by Honeysuckle and nib for the establishment of a buying group. RACS along with many other healthcare stakeholders was concerned that this buying group was a step towards a managed care system. RACS' concern is that moves toward managed care will:

- restrict patient choices,
- reduce quality of healthcare; and
- limit medical practitioners' autonomy

A need for all stakeholders to collaborate

Rather than moving in increments to a managed care style health system, along with ensuring appropriate funding to reduce public surgery backlogs and wait times, it is RACS' position that government should work with the sector to address the reasons why Australians are dropping out of private health.

The next Australian Government should as a priority convene the key players in the private healthcare sector, including private health insurers, private hospitals, device importers and manufacturers, and private specialists – represented by RACS and other peak bodies, at an initial forum tasked with seeking sector-wide buy-in on approaches to addressing falling private health insurance membership.

Reducing death and serious injury on our roads

It is RACS' position that the next Australian Government should:

- Implement a comprehensive action plan to support the latest National Road Safety Strategy.
- Focus on data collection, enhancement and application, with a specific strategy to enable the provision of data via the new national road safety data hub.

A National Action Plan for Road Safety

Each year across Australia more than 1,200 people are killed and 40,000 are hospitalised as a result of road trauma. This can only be described as a national epidemic which demands strong leadership and close collaboration from all levels of Government and communities.

The Australian Government recently announced a new National Road Safety Strategy. The Strategy aims to reduce the number of deaths on our roads by 50 per cent by 2030 and reduce the number of serious injuries by 50 per cent over the same period.

While RACS welcomes these targets, the absence of a detailed action plan to assist in achieving them is disappointing. Australia failed to meet the conservative targets outlined in the previous road safety strategy, and we will repeat the same mistakes unless the appropriate resourcing and accountability is dedicated to achieving our goals.

Many of the solutions to reducing Australia's devastating road toll and creating safer roads have already been identified, and there is a growing sense of frustration at the delays taken to implement proven life-saving initiatives. Examples of solutions that can be implemented to deliver better outcomes and significantly improve road safety include:

- Develop a national road safety data hub
- Verification of trauma networks at a jurisdictional level to improve post-crash care
- Link federal infrastructure funding to road safety outcomes
- Enhance vehicle safety standards and encourage the uptake of safer vehicles
- Assignation of the Office of Road Safety to a leadership role with genuine authority

Over many years and through multiple road safety inquiries, RACS and other key stakeholders have provided recommendations and initiatives to improve safety on our roads but ultimately the key is action, accountability, assessment and measurability of targets. All agencies and all levels of government need to take responsibility for road trauma and strive for zero deaths and major injuries on Australian roads by 2050.

Improved data collection and linkages

In 2020 RACS co-signed a submission to the Senate Joint Select Committee on Road Safety. This submission highlighted how the collection and linkage of data during the initial stages of the COVID-19 pandemic greatly assisted Australian Governments in their response to keeping the community up to date with daily updates on the number of Intensive care unit (ICU) beds occupied by COVID-19 patients, and with mitigating the virus.

A similar approach is needed to road safety. The community now has an appetite and understanding of hospitilisations and ICU numbers and the burden on the health system. It is imperative that clinicians and organisations have access to timely and high-quality data as an urgent priority.

RACS welcomes the establishment of the national road safety data hub, and we believe this presents an opportunity to develop a national data collection strategy. The New South Wales interactive crash statistics database is an example of the level of data that should be aspired to on a national scale. Verified trauma networks must be established in all jurisdictions.

Many of the solutions/vaccines to reduce the silent epidemic of death and hospitalisation from road injury can be actioned immediately. RACS calls on the current and future government to act with the urgency required to meet a target of zero deaths and serious injuries on Australian roads by 2050.

Safeguarding the health of all Australians from the threat of climate change

It is RACS' position that the next Australian Government should:

- Prioritise health in the context of Australia's Nationally Determined Contribution to the Paris Agreement.
- Commit to the decarbonisation of the healthcare sector by 2040, and to the establishment of an Australian Sustainable Healthcare Unit.
- Implement a National Strategy on Climate, Health and Wellbeing for Australia.

Climate change is described by the World Health Organization as "the greatest threat to global health in the 21st century."[1] Yet, climate action could be the greatest public health opportunity to prevent premature deaths, increase life expectancy, and to achieve health and economic co-benefits.[2, 3] To ensure that the health of all Australians is protected from the threat of climate change, we call on the Australian Government to: ensure that the health of all Australians is protected from the threat of climate change, we call on the Australian Government to:

Prioritise health in the context of Australia's Nationally Determined Contribution to the Paris Agreement

A stable climate is a fundamental determinant of human health and the aim to limit warming to 1.5°C is a critically important public health goal. The current emissions reductions target set by Australia is not sufficient to keep warming to 2°C.[4] This threatens the health of Australians, and people around the world. Significantly increasing ambition by Australia in its Nationally Determined Contribution under the Paris Agreement is needed to have a chance of avoiding the further disastrous health, economic, and environmental impacts of climate change.[5] This would best be achieved by the creation of a body that will appropriately prioritise the setting of targets to meet those agreed to under the Paris Agreement.

Commit to the decarbonisation of the healthcare sector by 2040, and to the establishment of an Australian Sustainable Healthcare Unit

The health sector is responsible for 7 per cent of Australia's greenhouse gas emissions.[6] Achieving net-zero healthcare will significantly contribute to emissions reductions in Australia and will lead to economic and health co-benefits.[7,8] A target of net-zero emissions by 2040 for healthcare in Australia, with an interim emissions reduction target of 80 per cent by 2030, is in line with similar commitments by the National Health Service in the UK and is broadly consistent with the goal of limiting global temperature rise to 1.5°C.9[10,11] Establishing an Australian Sustainable Healthcare Unit in the Australian Government Department of Health is necessary to ensure standardised and consistent measurement of health sector emissions, mapping evidence-based approaches to emissions reductions, and achieving nation-wide health sector outcomes.

Implement a National Strategy on Climate, Health and Wellbeing for Australia

A key recommendation from the 2020 Lancet Countdown on Health and Climate Change Policy Brief for Australia suggests that to protect wellbeing there must be a national climate change and health strategy.[12] A Framework for a National Strategy on Climate, Health and Wellbeing has already been developed by the health sector and health experts, and is supported by more than 50 health organisations.[13]

By implementing the systematic and ambitious actions on climate change and health described above, the Australian Government will demonstrate its commitment to the health and wellbeing of Australians, the economy, and the environment.*

*RACS would like to acknowledge that this text comes directly from a 2021 letter to the Prime Minister supported by numerous health sector stakeholders organised by Better Futures Australia

Committing to health security and long-term health systems strengthening in the Pacific

It is RACS' position that the next Australian Government should:

- Reverse the proposed funding cut to the Pacific Island Program.
- Commit to a funding envelope of at least $1.7 M AUD per annum, indexed, for the period 2022 – 2027.
- Support and invest in RACS' ability to influence the Indo-Pacific Region through the Pacific Island Program.

A critical and well-respected program facing proposed funding cuts

RACS has had a long relationship with DFAT as the leading provider for clinical services and health workforce development in the Pacific Island Program (PIP) across 11 Pacific Island Countries. This critical and well-respected program works in partnership with Pacific ministries of health, SPC and Fiji National University to enable health security and health systems strengthening across the Pacific region.

Something that we have all learnt from the pandemic is that poor health leads to poor outcomes in other priorities, such as the economy. It is clear that whatever other development priorities are held by Australian and partner countries, societal health must be an overriding, foremost principle.

Yet, amidst increased surgical demand due to Covid-19 impacts on specialised clinical service delivery, and an affected Pacific health workforce, RACS has been informed that there is a planned 43 per cent cut to the next iteration of the PIP (2022 – 2027). This decrease in funding will result in a loss of cumulative impact from years of Australian Government investment and potentially weaken health systems in a time of exacerbated health issues and increased demand.

The contribution of the Pacific Island Program to regional soft power

A central value of this program is the close relationships between the RACS Australian pro-bono specialist surgical teams and senior Pacific clinicians, ministers of health and other Pacific decision-makers and leaders. Having the ability to persuade and influence others through the power of the PIP contributes to the achievement of Australia's foreign policy. Aligned to the Foreign Policy White Paper's framework for Australia's international engagement, RACS seeks to contribute to a stable, prosperous and resilient Indo-Pacific in the wake of Covid-19.

A cost-effective and impactful program that should be supported

The PIP is one of the Australian Government's most cost-effective, value for money investments in the Pacific region. RACS provides 3:1 cost savings due to its invaluable pro-bono Specialist Volunteer teams that work in partnership with Pacific national clinicians to enable long-term workforce capacity building to deliver life-saving surgical procedures and training.

In 2019 RACS PIP deployed 224 pro-bono specialist volunteers across 11 specialities, carrying out 2918 patient consultations and working in partnership with national clinicians to perform life-saving surgery on 752 patients. 430 national clinicians received specialist training

On average, each Visiting Medical Team averts 323 Disability Adjusted Life Years (DALY) per visit.

All this is at a cost-saving of $2,746,353 per annum to the Australian Government, due to services being provided voluntarily.

Endnotes

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