ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2018-19 PRE-BUDGET SUBMISSION

Australian Government – The Treasury

December 2017

INTRODUCTION

Established in 1927, the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand and across the Indo-Pacific. The College is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees and international medical graduates.

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves, working closely with governments to deliver the best possible outcomes for patients.

Thank you for the opportunity to provide a pre-Budget submission.

KEY ISSUES

RACS has identified five key focus areas relevant to the 2018-19 Budget:

1. Maintaining high quality and timely access to healthcare
    a. Sustainable funding
    b. Health outcome data incorporating audits and registries
    c. Workforce maldistribution
    d. Global health
    e. Preventative healthcare measures
2. Recognition of the burden of trauma on the healthcare system
    a. Road trauma
    b. Ongoing funding for the Australian Trauma Registry
3. National leadership to reduce alcohol-related harm
    a. A volumetric tax
    b. Mandatory collection of alcohol-related Emergency Department presentations
4. Aboriginal and Torres Strait Islander health
    a. Incentive schemes for Aboriginal and Torres Strait Islander specialists
    b. Ear health
5. Surgical training and academic pathways
    a. Clinical academic training pathways

SUSTAINABLE FUNDING

Hospitals and healthcare providers across Australia are facing an increasing demand for services. Overall, funding for health has increased throughout the past decade; however, the cost of delivering care has also increased, as have public expectations about acceptable standards and access to health services.

Australians pay a high level of income tax compared to many other OECD countries; therefore, taxpayers expect the Commonwealth Government to fund state and territory governments adequately to provide timely access to high quality healthcare without additional out of pocket costs.

RACS acknowledges that healthcare budgets are finite, and that the Australian Parliament is directing considerable effort to improve the sustainability of Australia's healthcare system. The College has welcomed the opportunity to have direct involvement in the MBS Review, and is actively working on other key challenges which influence surgical services in Australia, including participating in the Choosing Wisely project, taking a stand against excessive surgical fees, and collaborating with private health insurers on clinical variation to support surgeons' understanding of their practice in comparison to their peers.

From 2003-04 to 2013-14, public hospital expenditure increased each year by around 8%. This growth has not been matched by an equivalent growth in Commonwealth funding, and is most clearly reflected in the length of waiting lists around the country. The funding arrangement between the Commonwealth and state/territory governments must include equal cost sharing responsibility for growing healthcare expenditure.

In all states and territories, waiting times for elective surgery continue to be a concern for surgeons and patients. The longest median wait times are for ophthalmology, ear, nose and throat surgery, and orthopaedic surgery.[1]

Delayed access to healthcare may lead to poorer health outcomes and is more costly in the long term. RACS is particularly concerned that Indigenous Australians have a longer median wait time and a higher likelihood of waiting more than a year for elective surgery than other Australians.

HEALTH OUTCOME DATA INCORPORATING AUDITS AND REGISTRIES

The best way to improve transparency of surgical outcomes is to fund audits and registries, use agreed definitions for disease, procedures and outcomes, and ensure that everyone is able to understand, interpret and value health outcome data.

As the Grattan Institute notes, lots of hospital safety information is collected in Australia, but not all of it is shared with the right people. A first step in improving hospital safety in Australia is to better use the information that is already collected, and to put it in the hands of people who can apply it.[2]

We believe a more strategic approach to health outcome data is required and would like support from the Commonwealth Department of Health, state and territory governments and other stakeholders to improve interpretation of outcomes. This is already happening via the RACS Australian and New Zealand Audit of Surgical Mortality, however it is generally agreed that much more could be done to improve understanding of morbidity outcomes.

Surgical audit and peer review are important strategies in maintaining standards in surgical care at the clinical level,[3] and clinical quality registries have been identified as a 2016-18 Australian medical research and innovation priority.[4]

The Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR) has demonstrated a continual decline in the number of individuals requiring revision hip and knee replacement procedures since its inception, and provided a major benefit to the hospital bottom line.[5]

Another example of audit which would improve patient outcomes and substantially reduce hospital costs is the Australia and New Zealand Emergency Laparotomy Audit Quality Improvement (ANZELA-

QI) initiative. Emergency surgery is a significant healthcare burden and constitutes one third to half of all general surgery admissions. The high mortality and variable outcomes, when compared to similar elective operations, are well known to clinicians.

International studies have shown that emergency laparotomy quality improvement has reduced overall hospital and intensive care length of stay. For the equivalent of an estimated A$400 000 per year,[6] the UK National Emergency Laparotomy Audit (NELA) reports a cost saving of £30 million (about A$54 million) per year.[7] The NELA was implemented to address inter-hospital variation, which has now been reduced. Following initial UK Government support for three years, a further five years funding was recently announced - a clear indication of the value. In Australia

It is estimated up to $400 million is spent each year in Australia providing care for approximately 15,000 patients needing emergency laparotomies, making this a high volume and high cost area of care.[8] Independent Hospital Pricing Authority data shows inter-hospital variation in processes and outcomes which could be addressed by ANZELA-QI.

RACS has also highlighted its concern about the current lack of post-operative surveillance capabilities for surgical mesh, and believes a comprehensive mesh tracking system is required so that patients can seek the opinion of their general practitioner, primary surgeon or another expert if their condition is deteriorating.[9]

RACS supports the public release of outcomes based data on surgical performance at a team (larger than five), institutional or national level. The reports need to be valid, reliable and trustworthy so that surgeons and patients can be confident that reports accurately reflect the standards of health care.

In the absence of systemic audit, RACS is working with Medibank Private to produce surgical variance reports which analyse indicators for common procedures within surgical specialities, including general, urology, otolaryngology, vascular and orthopaedic surgery.

Improved health literacy is central to people’s ability to enter into an informed agreement with their clinician and we stand ready to work with Consumers Health Forum and other groups to provide resources and information that may assist.

WORKFORCE MALDISTRIBUTION

To address geographic maldistribution of surgeons in regional and rural areas, RACS supports the ‘hub and spoke’ model which allows regional and rural hospitals to become involved in training networks with larger regional and metropolitan centres.

There is evidence to show that trainees return to work in regional settings after they qualify because they had a rewarding experience in these centres. To ensure this level of experience, regional hospitals need funding for training posts. This can best be achieved by funding posts as part of the Specialist Training Program that are aligned with workforce data to ensure specialists are being trained and located in areas of clinical need.

We understand this is a two-way process, and while we would like to see greater flexibility from the Commonwealth in terms of the criteria for funding of rural training posts, we need to work with our Training Boards to improve the efficiency of post accreditation.

GLOBAL HEALTH

Supporting access to safe and affordable surgical and anaesthesia care is important for Australia’s foreign policy because it promotes health and wellbeing, and thus economic growth.

Australia, as a co-sponsor of World Health Assembly resolution 68/15 to strengthen emergency and essential surgical care, has an opportunity to help realise the resolution’s intent through its strategy of support for low and middle income countries (LMICs) in the Indo-Pacific.

RACS manages global health programs and projects in various developing countries across the Asia-Pacific region, including Timor Leste, the Pacific Islands, Papua New Guinea, Myanmar, Nusa Tenggara Timur (Indonesia), and has formal linkages with several nations including China.

Ongoing funding for these programs is critical to address the shortage of trained and skilled national specialists in the region, which reduces the countries' capacity to deliver surgical and medical care to their populations.

An estimated 16.9 million lives were lost worldwide in 2010 from conditions requiring surgical care, and at least 77.2 million disability-adjusted life-years could be averted each year through provision of basic surgical services. More people die each year from lack of access to emergency and essential surgical care than do from HIV, TB, and malaria combined.[10]

It is estimated that by 2030, the lost financial output across the globe (total GDP loss) from death and disability due to continued poor access to safe and affordable surgery could total $12.3 trillion, reducing annual GDP growth in low and middle income countries by as much as 2%.[11] If investment is made in surgical and anaesthesia care however, countries will be healthier, more productive, economically active, and better trade partners. Australia and the region will benefit.

Financing surgical expansion in a way that decreases death and disability for patients, and maximises economic benefits for countries in the Indo-Pacific, is both feasible and cost-effective – amounting to at least a three-fold return on investment. Achievement can be realised by investing in two strategic areas:

Strategic Area 1: Surgical education, training, and workforce development

- Long term support of medical personnel as educators, clinicians, and leaders in their home countries is essential to sustaining the local workforce.
- Fully-funded scholarships to Australia support health professionals in the training of specific skills.
- Institutions that provide medical education such as universities require long term support to consistently deliver high-quality education at both undergraduate and post-graduate levels.
- National Health Plan development needs to be supported to incorporate surgical and anaesthesia care.

Strategic Area 2: Surgical infrastructure

- Primary Health care depends upon the support of functioning hospitals. Distressed first line hospitals are the biggest issue in global health.
- Health facilities need to be supported with fixed items of equipment and consumables required to perform the three bellwether procedures: caesarean delivery, laparotomy, treatment open fracture, and therefore most other procedures on the WHO essential surgery list.
- Strong information management is needed, including surgical audit, to report on surgical activity and outcomes.

Overall, investment in safe and affordable surgical and anaesthesia care represents value for money in the context of Australia's economic, trade, and political interests.

PREVENTATIVE HEALTHCARE MEASURES

Chronic diseases are responsible for nine out of every ten deaths in Australia.[12] The enduring impact of chronic disease on the sustainability of Australia's healthcare system and overall population health reduces the quality of life and functioning abilities of Australians.

Dealing with these diseases costs Australia an estimated $27 billion per annum, and accounts for more than a third of the national health budget.[13] The Australian Institute of Health and Welfare's latest Burden of Disease Study reported that at least 31% of the burden of disease in 2011 was preventable, being due to modifiable risk factors such as tobacco use, high body mass, alcohol use, physical inactivity and high blood pressure.

Australia currently has no national strategy to address alcohol-related harm, or the growing burden of obesity. Based on the success of taxation in reducing tobacco use, the Commonwealth Government should consider the use of taxes along with a suite of other measures to divert people away from consumer choices that negatively affect their health.

ROAD TRAUMA

For every road fatality in Australia (>1,000 per year), there are around 27 hospital admissions[14]. Road trauma costs Australia almost $30 billion per year[15] and there is variance in outcome of patients dependent on where they are treated. Quality of life outcomes depends on the care patients receive in every part of their journey.

Many people and organisations involved with road safety have a shared vision to reduce trauma from crashes on Australian roads. In 2010 all state and territory transport and infrastructure ministers set a target to reduce both deaths and serious injuries by at least 30 per cent by 2020, through the National Road Safety Strategy 2011-2020.

We are now more than halfway through the global decade of action on road safety, and statistics show fatality and injury trends are heading in the wrong direction. The 2016 road trauma summary from the national Bureau of Infrastructure Transport and Regional Economics showed a 7.5% increase in road fatalities, compared with 2015,[16] while road trauma hospitalisations have been steadily climbing since the beginning of the century.[17]

ONGOING FUNDING FOR THE AUSTRALIAN TRAUMA REGISTRY

The value of information and investigation of injury outcomes to improve the quality of trauma care cannot be overestimated. Understanding the cause, place and type of injury is essential to inform injury reduction strategies.

RACS congratulates the Commonwealth Government for providing three years' funding to the Australian Trauma Registry, which collects data from 27 major trauma centres across Australia, up to and including 2018. The registry is currently the only way to measure serious injury across Australia and benchmark quality of trauma care, and we urge the Government to consider its longevity beyond 2018.

A VOLUMETRIC TAX ON ALCOHOL

RACS has advocated against the harmful effects of alcohol for many years, not only for the increased risk of complication that it poses to surgical patients, but also for the broader ramifications it has on the sustainability of our public health system and society as a whole.

The Commonwealth Government needs to play a leading role in encouraging state and territory governments to adopt evidence-based measures that will deliver consistent and nation-wide reductions in alcohol harm, such as those that have been introduced in Newcastle, Sydney and Queensland. The most effective strategies and biggest priorities for action are pricing and taxation, reducing availability, and advertising and promotion.

Economic modelling commissioned by the Foundation for Alcohol Research and Education has shown that replacing the Wine Equalisation Tax and rebate with a ten percent increase to all alcohol excise and a volumetric tax on wine and cider would deliver $2.9 billion revenue and reduce alcohol consumption by 9.4 per cent.[18] However, despite its reported effectiveness, taxation as a strategy to reduce alcohol-related harm has been under-utilised in Australia.

ALCOHOL-RELATED EMERGENCY DEPARTMENT PRESENTATIONS

Government agencies monitor and report incidents of alcohol-related harm and some of the costs associated with alcohol abuse. However agencies do not monitor or report the total costs to the community, meaning we do not have a complete picture of the harm caused by alcohol.

RACS strongly supports the addition of alcohol-related presentations to emergency department patient data sets. Mandatory collection of these data would provide a clearer picture of the extent of alcohol-related presentations to hospitals, and an evidence base to inform and evaluate policy decisions.

SUPPORTING ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

The gap in health outcomes between Aboriginal, Torres Strait Islander and the rest of the Australian population is well established. To help address the gap, RACS aspires to increase the number of Aboriginal and Torres Strait Islander surgical Trainees and Fellows to mirror those numbers in the broader population, improve levels of cultural competence within the non-indigenous surgical workforce and advocate for improvements in Aboriginal and Torres Strait Islander Health.

The RACS Foundation for Surgery, in collaboration with the Australian Indigenous Doctors' Association and other partners including Johnson and Johnson Medical Devices, have established $76,000 in scholarships for Aboriginal and Torres Strait Islander medical students and doctors with an interest in surgical training. In 2016 RACS established an Aboriginal and Torres Strait Islander Surgical Training Initiative guaranteeing training positions for Aboriginal and Torres Strait Islander surgical training applicants who meet the selection standards.

RACS strongly supports the work of the Australian Indigenous Doctors' Association (AIDA), and looks forward to its development of a face to face cultural competency training program for specialists. Given AIDA's important contribution to equitable health and life outcomes and the cultural wellbeing of Aboriginal and Torres Strait Islander people, RACS encourages the Commonwealth Government to provide certainty through the provision of five year funding agreements with AIDA.

EAR HEALTH

The epidemic of ear disease among Aboriginal and Torres Strait Islander people can no longer be ignored. The World Health Organization has classified prevalence rates of chronic suppurative otitis media at above 4% as a "massive public health problem".[19] In September 2017 a Parliamentary inquiry into the hearing health of Australians revealed that at any one time up to 90 per cent of children in remote communities will be experiencing an ear infection.[20]

RACS requests the Commonwealth commit to ending preventable deafness through a two-stage process. The 2017 AMA Report Card on Indigenous Health also supports a national strategic approach to this issue.[21]

Stage 1 - A Ministerial Working Group or Taskforce is formed to:

- Establish national key performance indicators (nKPIs) and data collection standards, as was recently endorsed by the Australian Health Ministers' Advisory Council.
- Provide options for a national monitoring system and reporting framework which can be used by all states and territories to better quantify ear health status over time and identify and target areas of geographic need.
- Investigate and provide recommendations on:
  - mainstream access to ear care for Aboriginal and Torres Strait Islander people; and
  - referral pathways in each jurisdiction.
- Address the resolution of the May 2017 World Health Assembly on the prevention of deafness and hearing loss, which calls on member states to collect high quality population-based data on ear diseases and hearing loss in order to develop evidence-based strategies and policies.

Stage 2 – A national program is revamped/established to:

- Implement reporting on state/territory progress against the nKPIs.
- Improve incentives for the delivery of ear health services.
- Work with ACCHOs, jurisdictions, and other service providers to evaluate ongoing efforts and alleviate barriers to primary (ear) healthcare services.
- Deliver appropriate training to the primary health workforce.

- Identify and support evidence-based policy and research.
- Identify and alleviate breakdowns in the continuum of care.
- Ensure healthcare and education are appropriately targeted and coordinated.
- Guide investment.

This investment would deliver wide-ranging benefits across the healthcare spectrum for Aboriginal and Torres Strait Islander people, not just in the area of hearing health.

CLINICAL ACADEMIC TRAINING PATHWAYS

There has been considerable support from governments in the translation of medical research into improved patient outcomes including the establishment of a number of Advanced Health Research and Translation Centres throughout Australia and the Medical Research Future Fund. However, clinical academics, who are vital for bridging this gap between medical research and health outcomes, have been declining in numbers due to current training pathways being ad hoc and few and far between.

This situation for clinical academic surgeons greatly limits the ability to make advancements in translating health and medical research. To overcome this challenge, potential clinical academics including surgeons require standardised, clearly defined, and adequately funded training pathways, such as those established in the UK that reported an increase in clinical academic numbers within the first few years.

This initiative is crucial to prevent Australia falling behind other countries in introducing improvements in surgical processes and procedures, and the consequent improvements in the quality of patient care it can provide. RACS seeks the Commonwealth Government's support to fund and implement training pathways for clinical academics.

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