SOUTH AUSTRALIAN STATE ELECTION 2014

POSITIONS AND RESPONSES OF POLITICAL PARTIES

February 2014
1. Introduction
In the lead-up to every State and Federal election, the Royal Australasian College of Surgeons provides an opportunity for political parties to outline policy positions on key issues relating to the delivery of surgical services. We then distribute the responses to the membership and the wider community. The South Australian region of the College has developed this document which outlines the areas of specific concern to the College in the lead-up to the forthcoming South Australian election. The College believes, that appropriately informed policy positions, will allow the College to advocate effectively to ensure best outcomes for patients requiring surgical care in public hospitals in South Australia.

2. Background – Royal Australasian College of Surgeons
The Royal Australasian College of Surgeons, established in 1927, is a not-for-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand. Approximately 95 per cent of all surgeons practising in Australia and New Zealand are Fellows of the College (FRACS).

The College commits to ensuring the highest standard of safe and comprehensive surgical care for the community we serve through excellence in surgical education, training, professional development and support. As part of this commitment, the College strives to take informed and principled positions on issues of public health.

3. Key issues
The College has identified five key focus-areas pertinent to this election. They are:

- Provision of adequate specialist surgical training opportunities. In particular reference to the concept of single service multiple site model for service delivery in specialist and subspecialty surgical disciplines in the NALHN/CALHN jurisdictions.

- Access to surgical care in SA. The single service multiple site model for service delivery in specialist and subspecialty surgical disciplines in CALHN with particular reference to the final clinical capabilities of the nRAH and the TQE – including final configurations of ICU and Emergency Departments of nRAH and TQE as impacts on surgical trauma management (see below)

- Alcohol abuse and its impact on surgical trauma;

- Ensuring timely access to safe and effective child and adolescent surgical care throughout the state of South Australia with particular reference to paediatric services based on changes proposed in the NALHN;

- Model of trauma services provision for South Australia with particular reference to the capacity of the nRAH to perform as a Level 1 Trauma Facility and the proposed development of the LMHS as a major trauma facility

- The threat to surgical standards posed by reduction of funding for the South Australian Audit of Perioperative Mortality (SAAPM)
4. Specialist Medical and Surgical Specialty Training

An effective surgical service requires appropriate clinical loads, active clinical teaching, continuing professional development, and robust audit and peer review. Such a culture of excellence can only be sustained if these specific needs are acknowledged and addressed. Significant financial, infrastructural and cultural support from governments and health authorities is required to train and maintain the surgical workforce of the future.

Support for surgical specialty training

Background

The substantial increase in the number of medical graduates has led to an acute shortage of post-graduate training posts – both internships in our hospitals and places in the specialist medical colleges.

The Royal Australasian College of Surgeons, with its associated specialty societies, works with surgeons in the public hospitals to identify more training positions and ensure that as many Trainees as possible complete its training program.

While the College puts no cap on the number of Trainees it accepts, this is necessarily limited to the number of available surgical training posts in our teaching hospitals. The number of surgical training posts has not risen to meet the growing number of medical graduates who would like to pursue a career in surgery.

It is the College’s position that:

- With the recent and substantial increase in the number of medical graduates entering the workforce there is now commensurate pressure on postgraduate training opportunities. South Australia – as a smaller state – must ensure that the number of training positions in surgery are maintained or increased to meet pressure created by an aged population (e.g. in areas of cardiac and vascular surgery including endovascular surgery, oncological surgery and renal access and transplant surgery)

- With a need for an increased number of surgeons in particular specialties, there is a requirement for a strong commitment from state governments to increase the number of, and funding for, additional training posts.

- The State Government and through them, SA Health, must support trainers, ensuring protected time and appropriate environment for training by ensuring adequate staffing levels.

- The State Government, through SA Health, must have a current and reliable understanding of the College’s role (via its individual nationally based specialty boards) in assessing and accrediting new and established training posts.

- The impact of the redistribution of surgical services (in the single-service multiple site model and the hub and spoke model of high complexity low volume surgery in the hub and low complexity high volume surgery in the periphery) on training posts must be considered a critical factor in the final formulation of surgical services especially in considering division of services between NALHN/CALHN and within CALHN.
Response:

The College is seeking your response with regard to maintaining and increasing surgical training posts within the public hospital system.

5. Alcohol abuse and related violence and trauma

Alcohol-fuelled violence leads to serious trauma, often requiring surgical intervention. Recent cases of this highlighted in the media has led to proposals of changes to legislation to ensure stiffer penalties to serve as deterrent. Whilst the College supports these moves, the College believes that the root problem remains the inappropriate use of alcohol.

The need for action

Background

- About 10% of all Australians put their health at long-term risk by drinking too much, and 20% drink at a level that is risky in the short term;
- Each week, on average, 60 Australians die and a further 1,500 are hospitalised as a result of excessive alcohol consumption;
- Excessive consumption fuels violence and significantly contributes to crime;
- In 2007, one-third of 12-15 year old Australians and nearly 80% of 16-17 year olds had drunk a full-serve of alcohol;
- 80 per cent of alcohol consumed by people aged 14-24 is consumed in ways that put the drinker’s (and others’) health at risk;
- Alcohol has been causally linked to more than 60 different medical conditions, including cirrhosis of the liver, inflammation of the gut and pancreas, heart and circulatory problems, sleep disorders, male impotency, eye diseases and conditions, and alcohol dependence;
- Alcohol consumption raises the overall risk of cancer, including mouth, throat and oesophagus, liver cancer, breast cancer and bowel cancer;¹
- The rate of alcohol-attributable death among Indigenous Australians is about twice that of the non-Indigenous population.²

Laslett et al (2010) found that an estimated 367 Australians died and nearly 14,000 people were hospitalized because of the drinking of others, in the year studied, 2005. Interpersonal violence resulted in 182 deaths, of which 42% (77 deaths) were estimated to be attributable to another person’s drinking; a total of 1,802 potential years of life were estimated to have been lost. A total of 277 deaths of people aged 15 years and over were estimated to be due to another’s drinking and driving, with 31 of these being pedestrian deaths.

- Estimates based on 2005 police data indicate that more than 70,000 Australians were victims of alcohol-related domestic violence. Using national child protection data and Victorian measures of alcohol involvement, almost 20,000 children across Australia were victims of substantiated alcohol-related child abuse in 2006/7.
Coupled with the direct costs to the drinker from the Collins and Lapsley (2008) estimates, the total annual cost of alcohol related harm to the Australian community is $36 billion.

It is the College’s position that:

The College has taken a position to champion the ‘HOT’ issues. These are: Hours - Outlets - Taxes (HOT). As a community and society;

- We need to reduce the number of ‘Hours’ alcohol is available, particularly after 2am.
- We need to reduce the number of ‘Outlets’ where alcohol can be bought in our community.
- We need an effective alcohol Taxation and pricing policy to bring about behavioural change.

In recent weeks the College has received some media coverage nationally for this position and to identify the issues we believe need to be addressed.

The College supports both Government and broader community action to acknowledge the problem of alcohol misuse, to introduce legislation and regulation to protect the community, encourage appropriate alcohol use and embrace and model ways of responsible drinking.

Response:

The College is seeking your response to the ‘HOT’ issues and what other policies are in place to address the growing issue of alcohol-related harm and disease in the community.

References

1 National Health and Medical Research Council, Australian Guidelines to reduce health risks from drinking alcohol, (2009) citing Baan et al., Carcinogenicity of alcoholic beverages, Lancet Oncology 8: 292-93 (2007)


6. Access to Surgical Care in SA

Beds, LHNs and Surgical Units

Background

Data from the Australian Institute of Health and Welfare shows a steady decline in the number of public acute beds, from 3.1 beds per 1,000 population in 1996-97 to 2.6 beds per 1000 population in 2011-12. ¹,²

This decrease will be further compounded by the increased growth of the population aged 65 years and older, who experience more frequent hospital admissions and longer stays than younger Australians.

All credible studies show that bed shortages, in context of rising demand for elective and unplanned admission, causes blow outs in waiting lists and dangerous emergency overcrowding (‘access block’).

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It is the College’s position that:

- Elective surgery waiting lists are symptomatic of longstanding problems in Australia’s public health systems. Elective surgery waiting lists are only an indication of the number of patients being able to access outpatient services to get on these lists. Waiting times for outpatient appointments (e.g. in orthopaedic surgery, urology and spinal/back surgery) are also an indication of the stresses on an under-resourced health system.

- While some of these problems can be addressed by a commitment to greater efficiency, there can be no denying the need for greater investment in our public hospital system, and in its workforce. In South Australia, the State Health Care Plan (2007) which is, in part, premised on the nRAH and an expanded LMHS, has been promoted as an answer to the problem of surgery waiting lists times. It is the view of the RACS South Australian Region that, to the best of what information that is currently been made available, that these measures will not address the issue in durable way.

The College is seeking your response regarding:

- the total surgical beds, operating theatre numbers and capabilities, nursing (theatre and specialist procedural) staff and surgeon numbers for the immediate and longer-term future.

- the final configuration of the nRAH as pertains surgical beds, theatre capacities - including hybrid technical suites suitable for vascular and trauma surgery and interventions.

- the final configuration of surgical services within CALHN and NALHN.

We seek this information so that we can ensure surgeons, other clinicians, patients and the wider community are clear about the course of action proposed by the government, the timing for the implementation and the likely level of surgical service provision.

7. Trauma services in South Australia

Level 1 trauma care capability – nRAH and LMHS

Background

Multiple discussions between the College and representatives of the Central Adelaide Local Healthcare Network on the final configuration of surgical services at the new Royal Adelaide Hospital have so far failed to confirm the presence of surgical service configuration capable of dealing with multi-trauma at the level of a level 1 trauma facility.

It is the College’s position that:

With the development of a $3.8 billion facility and proposed planned infrastructure to deal with high complexity of surgical cases, the new Royal Adelaide Hospital would appear to be the appropriate principal location for the management of multiple and severe trauma. The definition of a level 1 trauma facility has previously been documented (see appendix A).
The College is seeking your response regarding:

- the capacity and configuration of the new Royal Adelaide Hospital to function as a Level 1 trauma facility. More specifically your response to the inclusion of a RAPTOR suite and a hybrid theatre capable of treating multi-trauma with vascular injuries, neurosurgical injuries, pelvic and abdominal injuries requiring interventional radiology treatment.

- the final configuration of the nRAH with respect to facilities for subspeciality treatment of multiple trauma.

- the planned transition of the Lyell McEwen hospital to a tertiary centre (if indeed this is achievable) and the resource allocation (capital expenditure on infrastructure and resident and specialists surgical staffing) to develop the range of surgical services required by the community it serves. Further, information on the timeline for the development of tertiary level surgical trauma services at the Lyell McEwen Hospital.

8. The maintenance of surgical standards

The South Australian Audit of Perioperative Mortality (SAAPM)

Background

In 2012, the state government funding for the SAAPM program was capped leading to a shortfall that required assisted funding from other quality assurance programs run by the College on behalf the State government, to assist in maintaining the viability of the SAAPM program.

After negotiations with the State government, through the public health and clinical systems Department of SA Health, the College was able to secure a limited commitment to funding for this important program up to the completion of the calendar year 2014.

It is the College’s position that:

The South Australian Audit of Peri-operative Mortality (SAAPM) is an important initiative of the College and its Fellowship to peer review the clinical management of deaths occurring during surgical admission in South Australia. Funding for this project is provided by SA Health.

The principal aim of SAAPM is to improve the quality of healthcare through feedback and education. In order to achieve this, evidence from local audit data is required.

Feedback in individual and group formats is produced. Individual feedback is thus provided to individual surgeons and aggregate data is disseminated to all surgeons and hospitals.

Surgeons are protected by statutory immunity through Commonwealth Qualified Privilege legislation. This legislation is designed to strongly encourage clinical professionals to engage in quality and safety initiatives in order to bring about improvements in care.

The College is seeking your response regarding:

A commitment to maintaining appropriate funding to SAAPM - an important and proven audit that serves a critical role in maintaining surgical standards in South Australia’s hospitals.
9. Child and Adolescent Surgical Services in South Australia

Child and Adolescent Services

Background

The Women's and Children's Hospital has served as a long-established centre for the provision of child and adolescent surgical services to South Australia. To a lesser extent, child and adolescent surgical services are also provided in other hospitals including the Flinders Medical Centre.

In the development of the generational health review (2003) and the subsequent development of the state health care plan (2007), child and adolescent surgical services were proposed to be developed in the northern region (NALHN) where a certain level of paediatric surgical services pre-existed. This was in the form of our outreach services from child and adolescent surgeons based at the Women's and Children's Hospital providing an outpatient and a monthly day surgery clinic. Child and adolescent ENT surgery has long been performed at the Modbury hospital by ENT surgeons trained and competent in child and adolescent ENT surgery (the bulk of which has been short-stay, low-complexity surgery).

The Deloitte’s Touche Review commissioned by the government into the Women's and Children's Hospital has led to a reduction of funding (closure 100 beds and reduction in nursing staff) due to a perception of a longer duration of stay in comparison to comparable facilities in other parts of the country.

The College, together with other clinical representative bodies, has raised concerns directly with the government over the basis of the findings - including the validity of the data analysis and the definition of “comparable” facilities.

The closure of the child and adolescent ward at the Modbury Hospital and a subsequent directive for transfer of acute child and adolescent presentations from the Modbury Hospital to the Lyell McEwen Hospital has ignited significant debate over the safety and care of acutely unwell children and adolescents in the northern Metropolitan area.

It is the College's position that:

Child and adolescent surgery is a defined subspecialty surgical discipline. The College has a defined program with requisite curriculum and competency endpoints to ensure that the highest quality of child and adolescent surgical expertise is available when such a member of the community requires surgical care.

The College is the only training body that provides child and adolescent surgical training.

The College has provided multiple inputs into the subject of child and adolescent surgical services in the Northern Adelaide Local Healthcare Network and on the associated issue of child and adolescent ENT surgical services within the northern Adelaide local healthcare network hospitals (Modbury and Lyell McEwen).

However, recent changes to the delivery of child and adolescent surgical care at these facilities have raised the College’s concern about the safety of child and adolescent surgical services in South Australia.

The College is seeking your response regarding:

- The provision of an appropriate system of acute child and adolescent surgical care
• The level of resourcing of the Women's and Children's Hospital with regard to meeting the demands placed on it to provide definitive child and adolescent surgical care.

• The appropriate care for patients aged between 12 and 18 presenting to the northern Adelaide local healthcare network of hospitals.

• How you will ensure that child and adolescent ENT services are provided in facilities with suitable equipment and infrastructure, with suitable ancillary and supporting staff to support ENT surgeons providing paediatric services.

Conclusion:
The Royal Australasian College of Surgeons – South Australia Region thanks you for your time in addressing these matters and we look forward to receiving your response by 26 February 2014.