Australian Doctors' Fund

Response to Productivity Commission position paper

September 2005

"Gammon's Law"
In a bureaucratic system, increases in expenditure will be matched by fall in production. Such systems will act like black holes in the economic universe, simultaneously sucking in resources and shrinking in terms of emitted production

Dr Max Gammon, British physician, 1960

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The Australian Doctors' Fund (ADF) has considered the Productivity Commission Paper, September 2005 and its draft proposals and submits this response together with recommendations.

1. **Australian Medical standards must be maintained**

   Australia has traditionally enjoyed a high standard of medical care. This has been achieved through a rigorous science based medical education programme followed by practical supervision and mentoring utilising the voluntary contribution of experienced clinicians through their recognised medical colleges. This system is understood, accepted and proven to deliver quality medical training. At the same time it has facilitated adaptation to embrace rapid change in medical technology and skills sets through a combination of generalised and specialised practice. It is a remarkably successful and durable model.

2. **Eroding confidence in the medical profession is not in the national interest**

   Confidence in the Australian medical profession is a key factor in the emotional and physical health of the Australian population. The consequences of a belief that doctors no longer represent the highest possible standards of medical education and training, or that a medical degree or the term "doctor" (in the medical context), can be acquired without the rigours of a traditional medical education would be such as to promote unnecessary generalised public anxiety at a time of increased uncertainty across the Australian community.

3. **Medicine is a discipline where roles must be clearly defined and delineated**

   Many of the technical divisions in medical practice have developed so as to clearly delineate roles and responsibilities in the interest of patient safety. Patients must be owned by an individual doctor who must be accountable for his/her treatment with clear lines of demarcation enabling safe handover of responsibilities when required. The doctor/patient relationship is the cornerstone of quality medical practice.

   Creating roles that blur the division between a medical practitioner and a non medical practitioner will promote uncertainty and lower the confidence of the Australian public in the medical profession. There is no proof other than theoretical speculation that such changes will enhance productivity. Indeed blurred roles will almost certainly lower the productivity of the existing medical workforce because of the extra demands on supervision.

   There is no evidence that the current defined roles undertaken by medical practitioners are a barrier to productivity. It is understood within the model that specialties may overlap i.e. spinal surgery may be undertaken by orthopods or neurosurgeons. The model provides for flexibility within the specialties and in general practice. e.g. many general practitioners now work more extensively in the initial phases of mental health. These changes are worked out within the profession with appropriate training and support, whilst at the same time discouraging doctors from working outside their field of expertise (a known hazard to quality and patient safety).

Patients are treated by individual doctors who take responsibility for their care. When teamwork is required clear lines of communication and authority are understood even in the most multi specialised procedure.

4. Workforce planning is not a science, it is at best speculation and guesswork

The only thing we know with certainty about medical workforce planning in Australia is that it has been consistently wrong (as has been estimates of future Commonwealth outlays on health expenditure despite an entire department of experts being devoted to this very process).

Predictions of future workforce demand and workforce requirements are at best speculative. This is particularly the case when long training times are envisaged in an environment of changing technology and medical breakthroughs that can make skills redundant overnight. What looks like an area of future shortage can quickly become an oversupply or vice versa. What is required is sensible, steady, and achievable expansion of the medical workforce whilst allowing individuals to make their own career decisions in an uncertain environment.

5. De-medicalisation (task substitution) has agendas other than productivity improvements

Proposals for de-medicalisation of the Australian health care system are often dressed up as productivity improvement initiatives. It is interesting that Prof Duckett, a leading proponent of task substitution advances the need for nurses to become quasi doctors on the grounds that "*failure to provide challenges in the workplace [for nurses] may lead to dissatisfaction among nurses who have contemporary levels of educational preparation and may effect retention.*"[1].

The reality that Prof Duckett will not confront is that expectations of nurses have been unrealistically enhanced through the enforcement of university based nursing education and the abolition of the apprenticeship inhospital training model. This has contributed to the shortage of nurses. The problem of nurse retention will not be solved by creating quasi medical roles for nurses or other allied health care workers. It will be addressed by ensuring a return to hospital based apprenticeship training for nurses with provision for advanced training as required.

The concept raised in the Position paper that doctors should delegate roles to non-medically qualified staff whilst at the same time maintaining clinical accountability "*for the health and safety of the patient*"[2] raises issues of medical indemnity. Cases of obstetricians being handed last moment complicated delivery cases makes this proposition a dangerous one for most doctors. This is not to say that there is not a role for nurses to work as nurses alongside doctors in medical practice.

Hence, lines of demarcation in traditional medicine exist to protect the patient and identify to the doctor where his/her responsibility starts and finishes. Any blurring of these lines is a receipt of unsafe practice as accountabilities and responsibilities become confused, assumed or hidden and patients fall through the cracks.

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[1] Health Workforce design for the 21st Century, Australian Health Review, May 2005, p 201, Duckett S J
[2] Productivity Commission paper, Summary L1

There has always been a plethora of individuals and groups who believe their status in health care delivery should be publicly elevated without the requirement of having to complete the academic and training standards required of doctors.

In some cases it is claimed that training is the equivalent of a medical degree and that complex surgery should be permitted for those who do not hold a qualified medical surgical qualification.

As has been previously stated, standards in Australia will only be maintained if every individual who cuts bone and tendon is required to meet the same standard of surgery etc. To the armchair expert, terms such as routine anaesthesia and routine surgery come easy. To the experienced medical practitioner there is never anything routine about anaesthesia and surgery.

6. Productivity will improve if government gets out of the way of doctors and lets them get on with the job

Given that a considerable amount of taxpayer funding is directed to the reimbursement of healthcare costs there is a tendency for government departments to believe that they have a legitimate right to control the delivery of health care and that the Australian medical profession are public servants masquerading as independent practitioners. The reality is governments reimburse health care costs, they do not deliver services. The growth of government intervention into the delivery of medical care is one of the major contributors impacting on the potential productivity of the medical workforce.

Anticipating threats of government control, our constitutional forebears enshrined anti-conscription provisions in the Australian constitutions. Many of the interventions now being considered to control the delivery of health care may have to be considered in light of these provisions.

7. Changes to Public patient financing will enhance productivity

"Many of the changes required to improve health workforce arrangements could only occur as part of broader health policy reform, including to the funding of health care in Australia. However, this is not the task currently before the Commission."[3]

Our public hospital system once community administered and supported is now predominantly State government owned and controlled. Funding is through block grants to the States who channel it through a growing bureaucracy into hospital budgets designed to react to political objectives as much clinical need. This funding system (command and control model) has predictably resulted in the operation of **Gammon's Law**, **namely that in a bureaucratic system, as government funding increases, productivity declines**. This major threat to the productivity of our doctors has gone unaddressed in The Productivity Commission Report. All Australians have been given a Medicare card and told they are entitled to unlimited, high quality health care on demand at any public hospital. In the absence of a price mechanism state governments have relied on rationing and strategic disruption to regulate demand in our public hospital system. Hence the public health care financing system enforces barriers to productivity in our public hospitals. The Australian Society of Orthopaedic Surgeons is on the public record as offering to double the amount of operating time in our public hospital system

[3] Productivity Commission Paper, Summary XVIII

with the existing workforce. These issues which are critical to the productivity of our health workforce have been declared off limits by the Productivity Commission in this report. This in itself is the major flaw in the report since a move to case by case (individual) funding in the public hospital system (possibly utilising vouchers) would most certainly enhance productivity. In Victoria where this approach has been partly implemented, the signs are encouraging in terms of commitment to productivity.

8. **Growing burden of compliance driven by government**
There is no mention in the report of the growing burden of compliance being placed on hardworking doctors and medical colleges to meet the agendas of agencies which have no direct bearing on patient care. Medical colleges in particular have spent hundred of thousands of dollars and thousands of hours complying with the demands of the ACCC and its NZ equivalent.

9. **The urban/rural imbalance will always be with us**
"*In the 5th Century BC, while the doctors of the capital were considered specialists the same was not true for those in the provinces*"[4]. The need for rural Australians to have access to quality medical care is fundamental. However there must also be an understanding that without massive reinvestment in rural hospital infrastructure it is unlikely that the universal problem of urban/rural imbalance in access to specialised medical services will be resolved. Initiatives designed to include rural training as an option and component of medical education are a positive move and are supported.

10. **Medical Education must be science based**
"Doctors lacking in anatomy are like moles: they toil in the dark and the fruits of their handiwork are mounds of earth"[5] Australian medical education standards must ensure that all medical students receive a comprehensive practical education in anatomy, physiology, microbiology, biochemistry, pharmacology and pathology as an essential requirement and foundation of their medical education and hence reverse the downgrading of these basic medical sciences.

[4] The Illustrated History of Medicine, Jean-Charles Sournia (Prof), p 46
[5] Friedrich Tiedemann 1781-1861

Conclusions

1. There is no compelling case or public demand for changing the way doctors have traditionally been educated, trained and recognised rather the Commission should be encouraging State and Federal Governments to declare confidence in existing medical colleges and their ability to deliver high quality medical training. The national interest requires public confidence in the medical profession and recognition for its achievement. Any attempt to de-medicalise the Australian medical workforce will generate public anxiety and uncertainty at a time when Australians want security and predictability.

2. Rather than experiment and re-engineer the existing medical workforce, the Productivity Commission should recommend the removal of barriers which are inhibiting existing workforce productivity including recommending changes to the way public hospital patients are funded. Individual patient funding on a case basis and the de-bureaucratisation of our public hospital system would greatly enhance the productivity of the Australian medical profession as would a sizeable investment in mental health infrastructure and support services.

3. Having detailed the plethora of bureaucracy (11 agencies involved in workforce planning) adhering itself to the delivery of health care services in Australia the Productivity Commission recommends reorganisation into more centralised (and perhaps bigger) bureaucratic structures.

   The Commission would be better placed to recommend ways of getting Government and its agencies out of the role of second guessing independent professions and hence encouraging those professions to achieve the highest standards of self governance within an appropriate and supportive, regulatory environment.

4. The Singaporean health care system could serve as a starting point for any organisation interested in productivity improvement. Broadly speaking Singapore is delivering 1st class health care at half the cost, with half the Australian medical workforce equivalent.