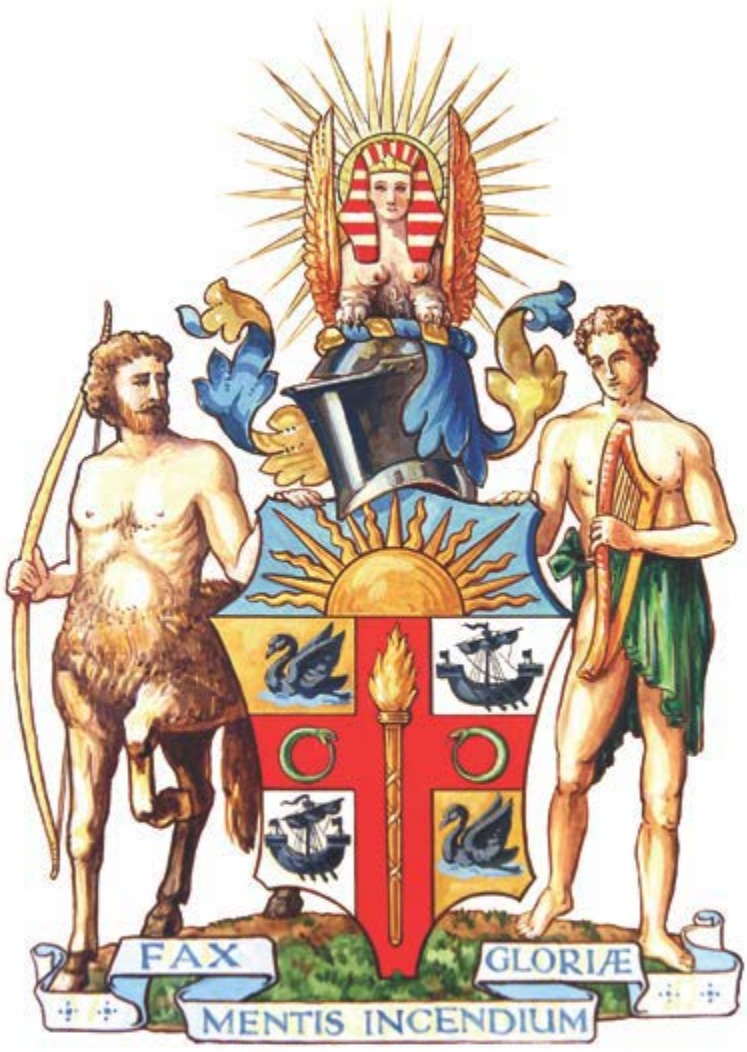

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

NSW STATE ELECTION 2015
POSITION STATEMENT

February 2015

Introduction

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. The College is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. There are nine surgical specialties in Australasia being: Cardiothoracic surgery, General surgery, Neurosurgery, Orthopaedic surgery, Otolaryngology Head-and-Neck surgery, Paediatric surgery, Plastic and Reconstructive surgery, Urology and Vascular surgery.

Throughout both countries surgeons play an active role in health care via membership of government committees, leadership within public hospitals and through promotion of health and safety messages to the broader public. Our College commits to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves and as part of this commitment, the College strives to take informed and principled positions on issues of public health.

The RACS NSW Regional Committee works closely with the Four Pillars of the Ministry of Health, and in the lead up to the next NSW state election the Committee offers an opportunity for political parties to outline policy positions on key issues relating to the delivery of public hospital surgical services. These responses are then forwarded to surgeons within NSW and the broader community. This document outlines areas of specific concern to Fellows, Trainees and International Medical Graduates who contribute to the provision of high quality surgical services in NSW, and who interact with and advocate for the communities in which they live.

Key issues

The NSW Regional Committee has identified six key issues:

1. Provision of **adequate specialist surgical training** opportunities.
2. **Alcohol abuse** and its impact on the incidence of traumatic injury, and **societal effects.**
3. **Timely and safe access to surgical care throughout NSW**, particularly:
    - improving rural access to surgical services
    - ensuring that increasingly complex surgical procedures remain accessible to the NSW public.
4. The NSW Government's **response to changes in the Commonwealth Health Budget.**
5. Support for **public hospital bariatric surgery services** and multidisciplinary clinics.
6. Establishment of an **integrated training pathway for clinical academics** to meet the future healthcare needs of New South Wales and Australia**.**

1. Specialist medical and surgical specialty training

A world class surgical service requires:

- Appropriate clinical loads
- Active clinical teaching
- Continuing professional development
- Robust audit and peer review guaranteeing patient safety.

To maintain such high quality care, a high standard of training and education for surgical trainees is paramount. 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 and appropriate working hours

Background

A substantial increase in the number of medical graduates has led to an acute shortage of post-graduate training posts. The College, through its associated specialty societies, strives to identify suitable training positions and to ensure that all trainees have opportunities to complete the training program to the standard required. The Fellowship of the Royal Australasian College of Surgeons (FRACS) is recognised throughout the world for its high standards and quality of training. The College does not cap the number of trainees it appoints, but positions are limited by the number of suitable, available surgical training posts in our teaching hospitals.

Surgical trainees, as employees of public hospitals, have defined rosters which detail normal hours and rostered overtime. Most hospitals have a standard 38 hour working week, with considerable penalty rates applied for overtime hours. As a consequence of budgetary pressures, public hospitals restrict the amount of overtime that junior doctors are permitted to do.

However, for surgical trainees to successfully complete the minimum training requirements of the RACS Surgical Education and Training program they require an adequate clinical load, defined education sessions with quarantined teaching time, and the opportunity to undertake surgical procedures under the guidance of experienced consultant staff.

Loss of Commonwealth funding for training such as the Specialist Training Program (STP) also impacts on the ability to create innovative approaches to specialist training such as in private hospitals or non-hospital environments. This further limits both the number of training posts available, and the clinical exposure of trainees to procedures that may not be observed in a public hospital setting.

It is the College's position that:

- Our community is best served by having appropriate numbers of well-trained surgeons with an adequate breadth and depth of training and exposure to a variety and intensity of clinical experience within high-quality healthcare institutions.
- The College, through its specialty societies, approves training positions in high quality centres providing adequate clinical exposure and a structured education program. Such a program requires resources and quarantined time to support trainees and trainers. To support the future of a world class surgical service the College aims to approve as many appropriate training positions as are accessible. Currently the College has no plans to extend the training time necessary to acquire the fellowship of the Royal Australasian College of Surgeons (FRACS). However, we cannot lower the acceptable standards of knowledge and skills required to successfully complete the program.
- The College believes that a 55-65 hour work week would satisfy the requirements compatible with affordable service provision, continuity of care and quality specialist training with appropriate experience, but still adhere to the concept of safe workplace practices, to which

the College is committed. Overtime should be rostered but affordable for jurisdictions. The College's Trainee Association (RACSTA) supports this position.

- The NSW Government is the direct funder of public teaching hospitals throughout NSW, and thus a key stakeholder in the development of trainee and trainer employment contracts. It is essential that the Government appropriately resources the infrastructure and workplace arrangements that facilitate quality surgical training and education.
- The NSW Government must continue to support providers of surgical education and training, ensuring paid, protected teaching time, and facilitating an appropriate environment for training by ensuring adequate staffing levels.

The College requests your response to the following questions:

How will your Government:

- Advance and maintain the infrastructure that supports surgical training in public, private, metropolitan and rural hospitals throughout NSW?
- Preserve dedicated time for teaching and training, including time for surgeons to develop their teaching skills?
- Support efforts by the Ministry, principally HETI and the NSW Committee, to improve rural supervision and availability of places in rural hospitals?
- Implement an affordable solution to overtime hours worked by surgical trainees to maintain the timeliness and integrity of the training program? One solution would be to extend the 'standard' working week of 38 hours to 50 hours at the rostered rate, with any further overtime to be charged at the penalty rate.

2. Alcohol abuse and related violence and trauma

Background

The NSW Government is aware of the harms caused by excessive alcohol intake. Violent behaviour associated with alcohol abuse leads to serious traumatic injury, which often requires surgical intervention. Such harm can change the lives of victims and their families. Furthermore, alcohol-related illness places a significant burden on public hospital resources.

The College supported the strong action the NSW Government took in January 2014 to prevent alcohol-related violence. Changes to legislation, including the development of a Sydney CBD Entertainment Precinct, with 3am last drinks, a 1:30am lockout, and a freeze on new liquor licenses are in line with our College's position. These measures have led to marked decreases in violent incidents, reduced alcohol-related presentations to the Emergency Department (ED) at St Vincent's Hospital, and a greater sense of safety reported by residents and patrons in the Entertainment Precinct. The College continues to advocate for the legislative changes to be made permanent, and to be rolled out more broadly.

NSW was noted to be the most improved state in terms of alcohol policy in the 2014 National Alcohol Policy Scorecard, having increased its score by ten percentage points since 2013. Yet the overall score of 41% supports the position of the College that more needs to be done to reduce alcohol-related harm in NSW.

The College acknowledges the NSW Government's initiatives to reduce alcohol-related harm, and we encourage the Government to allow the current legislative trial to run its full course, rather than reviewing it six months earlier.

Statistics

- In NSW from July 2013 – June 2014, alcohol was a factor in 12,494 non-domestic assaults, 9,939 domestic violence assaults and 1,646 assaults on police.[1]
- An overwhelming majority of people in NSW (80 per cent) believe that Australia has a problem with alcohol and 80 per cent also think that more needs to be done to reduce alcohol-related harms.[2]
- The total annual cost of alcohol abuse in NSW has been estimated at $3.87 billion (or $1,565 per household in NSW), including lost productivity in the workplace and home, of which $1.029 billion (or $416 per household) is the cost to NSW government services.[3]
- In an average year in NSW, alcohol is responsible for more than 1,200 deaths and more than 50,000 hospitalisations.[4],[5]

It is the College's position that:

Raising the barriers to purchasing alcohol is an effective means of reducing alcohol consumption and alcohol-related injury. The College's key messages are to tackle Hours - Outlets - Taxes (the "HOT" issues).

Government agencies monitor and report incidents of alcohol-related harm and some of the costs associated in responding to alcohol abuse. However agencies do not monitor or report the total cost of alcohol abuse, which means the NSW Government does not have a complete picture of the harm caused by alcohol in terms of its costs and effects on society.

The College requests your responses to the following questions:

Will your Government support:

- A state-wide roll-out of the lock out laws?
- Mandatory collection of alcohol sales data across the state?
- Mandatory collection of data on the number of alcohol-related presentations in emergency departments?
- Collection of a broader range of data related to alcohol-associated illness and injury?

If not, how will your Government:

- Maintain or reduce the number of 'Hours' alcohol is available (1:30am lockout and 3am last drinks).
- Maintain or reduce the number of 'Outlets' where alcohol can be purchased in our community.
- Actively engage with bodies such as our College, the National Alliance of Action on Alcohol (NAAA), the Australian Medical Association (AMA), and the NSW/ACT Alcohol Policy Alliance (NAAPA) to identify and develop other policies to address the growing issue of alcohol-related harm and disease in the community?

Would your Government also consider:

- Lobbying the Commonwealth Government to introduce a volumetric tax on alcohol?
- Supporting initiatives that facilitate the community's ability to be involved with decisions about licensed venues, such as via a dedicated website, or a Community Defenders' Office?

3. Timely and safe access to surgical care in NSW

Background

[1] NSW Bureau of Crime Statistics and Research (2014) *NSW Crime Tool*
[2] Foundation for Alcohol Research and Education (2014) *Annual Alcohol Poll: Attitudes and Behaviours*
[3] Audit Office of NSW (2013) *Cost of alcohol abuse to the NSW Government*
[4] Health Statistics New South Wales (2011-2014) *Alcohol attributable deaths*: http://www.healthstats.nsw.gov.au/Indicator/beh_alcafdth/beh_alcafdth?filter1ValueId=&filter2ValueId=; *Alcohol attributable hospitalisations:* http://www.healthstats.nsw.gov.au/Indicator/beh_alcafhos
[5] NSW/ACT Alcohol Policy Alliance (2014) *NAAPA 2015 NSW Election Platform*

The Australian Institute of Health and Welfare (AIHW) reported a steady decline in the number of public acute beds, from 3.1 beds per 1,000 population in 1996-97[6] to 2.6 beds per 1,000 in 2011-12.[7] As the population ages, the decline in per capita beds will be further exaggerated by the more frequent hospitalisations and longer stays typical for older individuals. High bed-occupancy rates are associated with greater risks of hospital-associated infection, access block, and negative impacts on staff health.

In the United Kingdom, the Department of Health determined that bed-occupancy rates exceeding 85% in acute care hospitals are associated with problems for both emergency and elective admissions.

Bed-occupancy rates influence ED performance in NSW. Published performance data[9] show a significant negative association between bed occupancy rates and ED admission performance ($r = -0.48$; $P = 0.03$) in the 20 largest general public hospitals. Studies have shown that bed shortages, in the context of rising demand for elective and unplanned admission, can cause blow-outs in waiting lists and dangerous ED overcrowding.

The College, through its representation on the NSW Surgical Services Taskforce, has worked collaboratively with the NSW Government to facilitate efficiency initiatives within public hospitals. This has resulted in a significant reduction in patients waiting more than 12 months for non-urgent surgery, from 713 patients in 2009 to 215 in 2014. The percentage of patients waiting more than 365 days is one of the lowest in the nation, but the median wait time for elective surgery is 49 days, the longest in Australia.

Using elective surgery waiting times in isolation to assess health system performance will fail to adequately address the underlying constraints on service provision. A major issue relates to patients waiting months to access public hospital outpatient clinics, the "waiting list to get onto the waiting list". This is particularly pertinent to clinics for orthopaedics, urology and spinal/back surgery. Available bed numbers and surgery waiting lists alone will not give accurate information about the underlying pressures on the NSW health system.

Since the 2011 publication of Future Arrangements for Governance of NSW Health, Local Health Districts (LHDs) and Specialty Health Networks have had responsibility for hospital and health service delivery. The Ministry of Health and LHDs moved to a purchaser-provider relationship via an annual service agreement, by which specific services are funded with Activity Based funding and/or block funding. When the financial resources paid by Government for surgical services do not meet the cost of service provision, LHDs have responded by implementing project design to increase theatre throughput and efficiency; and limiting the number of elective surgical procedures.

Once maximum efficiency processes are implemented, the only remaining measure an LHD can implement to maintain fiscal responsibility is to reduce the number of elective surgical procedures via:

- Extended holiday closures
- No back-filling of lists when a surgeon is absent
- Cancellations due to access block.

Discussions around opening specific numbers of extra inpatient beds are therefore irrelevant unless sufficient funding is allocated to permit performance of the numbers of procedures necessary to reduce median waiting times and to comply with the National Elective Surgery Target.

Access to surgical services throughout metropolitan and rural centres is affected by distance; geographical and professional isolation; availability of clinical expertise and ability to attract clinicians to areas of need; the need to maintain sustainable regional and metropolitan services; the challenge of maintaining high quality services in lower volume centres; and the significant interaction that exists between the Commonwealth and state funding systems.

It is the College's position that:

- Bed numbers and surgery waiting lists do not give accurate information about the underlying pressures on the NSW health system.
- Waiting times for outpatient appointments further contribute to the delays in patients accessing surgical services in a timely manner. The increased provision of public hospital outpatient clinics would also provide greater clinical exposure and experience for surgical trainees.
- Many of these problems have been addressed by a commitment to greater efficiency, but greater investment is required in our public hospital system.
- Strategic investment in infrastructure, staff development, and ongoing operational funding are required to maintain and develop the quality and range of surgical services that are available to the NSW public, and which can be delivered in an equitable and timely manner in regional and metropolitan settings.
- While proposals to divert low-complexity elective surgery to private hospitals or public-private partnership arrangements may reduce waiting list numbers in the short-term, there is a risk that the acuity and complexity mix of public hospital patients will increase. This further complicates long-term planning of resources within our public hospital system, diminishes training opportunities for trainees, and may create confusion over the responsibility for the future care of these patients.

The College requests your response to the following questions:

How will your Government:

- Work with LHDs to maintain existing surgical staff numbers, while implementing plans to increase, train and sustain the workforce required to provide surgical services in NSW currently and into the future?
- Deliver the necessary resources to increase inpatient beds?
- Provide infrastructure including operating theatres with hybrid endovascular capabilities and robotic surgery where required?
- Upgrade out of date equipment?
- Liaise with specialist groups to discuss any planned concentration or redistribution of surgical services throughout NSW metropolitan and regional hospitals, especially as they pertain to complex cancer surgery?
- Negotiate with LHD Clinical Councils when demand for services exceeds projected numbers, to provide extra funding without penalty if all efficiency measures have been met?

4. Commonwealth Health Budget funding changes

Background

The 2014 Commonwealth Budget proposed significant changes that could impact on the delivery of health and surgical services in the states and territories. While some of these measures have not passed the Senate, others are already in place and directly impact on health service planning.

Funding promised to the states under the *National Health Reform Agreement 2011* has ceased, and from July 2017 efficient growth funding will be replaced with indexation for CPI and population growth. This is expected to cost $1.8 billion over four years. Reward funding to states for Emergency Department and Elective Surgery targets under the *National Partnership Agreement on Improving Public Hospital Services* worth $201 million from 2015-2016 is no longer available.

Changes to the Private Health Insurance Rebate and the Medicare Levy Surcharge may alter the proportion of patients with private health insurance and place additional strain on NSW public hospitals.

Following the release of the Budget, the NSW Government claimed that NSW hospitals would be forced to close about 300 beds from July 1 2015 because of cuts to the health budget, and while the state could bear the impact in the short term, the cuts were unsustainable unless there is a complete overhaul of Commonwealth-State Health Finance Agreement.

It is the College's position that:

The interface between state and Commonwealth health funding is complex, and any changes to the national health budget impact directly on the ability to deliver surgical services in NSW. The College is on the record as supporting a single funder health system. In the absence of such a system, clear lines of communication and partnership are necessary to ensure that health care and surgical service delivery are not compromised due to discussions related to cost-shifting.

The College requests your response to the following question:

- How will your Government campaign for equitable health resource allocation between the states and Commonwealth Government to ensure the future of health funding for NSW, thereby preserving quality surgical services in the short and long term?

5. Support for public hospital bariatric surgery services and multidisciplinary clinics

The growing incidence of obesity and Type 2 diabetes globally is one of the most challenging contemporary threats to public health.[6] Uncontrolled diabetes leads to complications, including myocardial infarction, stroke, blindness, neuropathy, limb loss and renal failure. Despite improvements in medical management, fewer than 50% of patients with moderate-to-severe Type 2 diabetes actually achieve and maintain control of blood sugar.

Substantial weight loss has major health benefits. Bariatric surgery can rapidly improve control of blood sugar and cardiovascular risk factors in severely obese patients with Type 2 diabetes.[7]

Productivity and health system costs of obesity (and comorbidities) reached $7.7B in 2009.[8] The yearly cost of managing each patient with diabetes averages $10,900 (ranging from $9,095 to $15,850, depending on the presence of complications).[9] A Medical Services Advisory Committee report in 2003 costed gastric banding at just over $9,000 per procedure, and gastric bypass at just over $8,000.[10]

Bariatric surgery compared to no surgery is cost effective in adults with obesity. The cost effectiveness of bariatric surgery tends to increase where patients are severely obese; newly diagnosed with diabetes; and/or younger.

Obesity remains one of the last areas in which lack of equity in access to care is regarded as acceptable. Governments and public hospitals continue to disregard their responsibilities for patient care in this area.[11] Currently, Medicare pays for privately insured patients to undergo obesity surgery, while uninsured patients are denied access to surgery in public hospitals. This raises significant issues of distributive justice that should be addressed.

The College requests your response to the following questions:

- Will your government recognise the urgent need to increase the availability of bariatric surgical services including multidisciplinary clinics in the public sector?
- How will your government enhance the resources required for LHDs to develop and maintain bariatric services?

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[6] Saydah SH, Fradkin J, Cowie CC. *Poor control of risk factors for vascular disease among adults with previously diagnosed diabetes*. JAMA 2004; 291:335-42.
[7] Buchwald H, Estok R, Fahrbach K, et al. *Weight and type 2 diabetes after bariatric surgery: systematic review and metaanalysis*. Am J Med 2009;122(3):248.e5-256.e5.
[8] Medibank Health Solutions (2010) *Obesity in Australia: Financial impacts and cost benefits of intervention* - report by KPMG.
[9] Colagiuri S, Colagiuri R, Conway B, et al. (2003) *DiabCo$t Australia: assessing the burden of type 2 diabetes in Australia*. Canberra: Diabetes Australia.
[10] Medical Services Advisory Committee, Australian Department of Health and Ageing (2003) *Laparoscopic adjustable gastric banding for morbid obesity*. MSAC reference 14. Assessment Report. Available at: www.msac.gov.au.
[11] Talbot ML, Jorgensen JO, Loi KW (2005) *Difficulties in provision of bariatric surgical services to the morbidly obese*. Med J Aust; 182: 344-347.

6. **Establishment of an integrated training pathway for clinical academics to meet the future healthcare needs of Australia.**

Background

Clinical academics make a major contribution to public medicine, through research, education and leadership, but currently no curriculum or clear pathway exists for medical professionals to develop an academic medical career. With half of the academic workforce estimated to leave in the next ten years, it is critical that an integrated training pathway is developed to improve career opportunities and maintain the high quality research outcomes essential for continuous improvements in patient care.

The College in NSW hosted an inaugural International Summit on Academic Career Pathways in Australia and New Zealand in November 2014. More than 50 participants, including clinical academic leaders and government representatives, met to discuss how to build a sustainable clinical academic workforce.

Essential enabling factors including mentoring, flexible training pathways, sustainable funding and remuneration models were identified. The potential to support a target percentage of medical graduates to embark on an academic medical career was discussed.

It is the College's position that:

Surgeons can contribute significantly to the improvement of health care through clinical research, but this requires the allocation of appropriate resources, and quarantined time for surgeons and trainees to undertake clinical or basic sciences research and associated academic activity. The College acknowledges the establishment of the NSW Medical Research Support Program by the NSW Government as part of the Office for Health and Medical Research, which provides infrastructure funding on a competitive basis to health and medical research organisations.

The College requests your response to the following questions:

How would your Government:

- Support the preservation and quarantining of time for surgeons and trainees to conduct research, and participate in academic activity?
- Support academic networks throughout metropolitan and regional NSW to allow surgeons and trainees to develop research skills and qualifications? A mentor program with established researchers providing guidance would be an essential component.
- Foster a research environment that expedites translation of research outcomes into practice.
- Enhance existing research resources and facilitate collaboration with surgeons.
- Support the establishment of a NSW Surgical Outcomes Research Centre?

The NSW Regional Committee of the College thanks you for your time in considering these issues. We would appreciate receiving your response by 28 February 2015.