7. **THE AUSTRALIAN HEALTH MINISTERS’ CONFERENCE AND THE AUSTRALIAN MEDICAL WORKFORCE ADVISORY COUNCIL**

**History of workforce planning in Australia**

7.1 The Commonwealth Department of Health and Ageing submitted:

[un]til the late 1980s, Australian governments largely allowed the size, structure and other features of the medical workforce to be determined in an unregulated environment. In the 1960s and 1970s, national health spending as a proportion of GDP began to increase rapidly. Advances in medical science increased patient expectations for health care and medical education expanded considerably. This expansion then created an oversupply of practitioners as population growth slowed, new technology realised productivity gains, numbers of practitioners migrated to Australia, and health care treatment approaches changed to include greater use of day surgery and shorter hospital stays.

Attention focussed on the size and distribution of the medical workforce as medical services expenditure increased rapidly, while the market failed to correct geographic and sectoral undersupply of practitioners. Governments began to focus on containing costs in all areas of the health system and ensuring that the best use was made of resources in realising health outcomes. From the 1984 introduction of Medicare, most medical services were substantially subsidised by the Commonwealth on a universal basis, accounting for large and increasing expenditure outlays. Significantly, spending on primary medical care was observed to increase with the supply of practitioners, independently of population need.

At the same time, distribution of the workforce remained very uneven, with persistent shortages in rural and remote areas, despite oversupply of general practitioners (GPs) in capital cities. Apparent shortages in some specialist disciplines, particularly affecting rural and remote areas and the public hospital system, became a focus of attention in the early 1990s, together with lack of reliable data with which to analyse the extent and location of these shortages.

It was in this context that Australian governments began to more closely analyse and plan the medical workforce to match the workforce with population health needs. Planning and intervention since then has amounted to a complex task of slowing the overall growth of the workforce (and establishing an appropriate practitioner to population ratio), while increasing the supply of practitioners in certain geographic areas and in particular specialties. A second arm of planning, of importance for both health outcomes and cost containment, has been to ensure that the workforce is properly trained.

The measures introduced to achieve these ends have included capping of medical school intakes and restrictions on practitioners’ access to Medicare benefits. This fine-tuning has not been simple to achieve, as individual practitioners (rather than governments) have ultimate choice over where they work, and because the fee-for-service public subsidy of medical care blunts market pressures, which would otherwise move doctors to where they are needed.¹

7.2 The establishment of the Australian Medical Workforce Advisory Committee (AMWAC) in 1995 was a key measure introduced by Commonwealth, state and territory governments to assist medical workforce planning. AMWAC is an advisory committee to the Australian Health Ministers Advisory Council (AHMAC)² and through AHMAC to the Australian Health Ministers’ Conference (AHMC).

7.3 AMWAC provides advice to AHMAC, and through AHMAC to the AHMC, on national medical workforce matters, namely:

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¹ Commonwealth Department of Health and Aged Care submission, 13 June 2001, pp6-7.
² A committee comprising senior officials from Commonwealth, state and territory health departments which supports the Australian Health Ministers’ Conference.
• the structure, balance and geographic distribution of the medical workforce in Australia;
• the present and required education and training needs as suggested by population health status and practice developments;
• workforce supply and demand;
• medical workforce financing; and
• models for describing and predicting future workforce requirements.

7.4 In particular, AMWAC recommends targets for the number of trainees in particular medical specialities, including the surgical sub-specialties. AHMAC and ultimately the AHMC then determine whether to endorse these targets.

7.5 The current members of AMWAC are:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/nomination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor John Horvarth – physician</td>
<td>Independent chairman</td>
</tr>
<tr>
<td>Mr Bob Wells – Commonwealth Department of Health</td>
<td>Nominee of AHMAC</td>
</tr>
<tr>
<td>Dr Jeanette Young – Tasmania Department of Health and Services</td>
<td>Nominee of AHMAC</td>
</tr>
<tr>
<td>Dr Richard Madden – AIHW</td>
<td>Nominee of the AIHW</td>
</tr>
<tr>
<td>Dr Robert Bain – Australian Medical Association</td>
<td>Nominee of the Australian Medical Association</td>
</tr>
<tr>
<td>Dr Lloyd Toft – Medical Board of Queensland</td>
<td>Nominee of the Australian Medical Council</td>
</tr>
<tr>
<td>Professor Allan Carmichael – University of Tasmania</td>
<td>Nominee of the Australian Vice Chancellors’ Committee</td>
</tr>
<tr>
<td>Dr David Theile – surgeon (former president of the College)</td>
<td>Nominee of the Committee of Presidents of Medical Colleges</td>
</tr>
<tr>
<td>Dr Mary Mahoney</td>
<td>Nominee of the Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>Mr Bill Burmester</td>
<td>Nominee of the Commonwealth Department of Education, Science and Training</td>
</tr>
<tr>
<td>Mr Abul Rizvi</td>
<td>Nominee of the Commonwealth Department</td>
</tr>
</tbody>
</table>

3 Table 7.1 compiled from the AMWAC website at http://amwac.health.nsw.gov.au, Membership of the Australian Workforce Advisory Committee.
7.6 AMWAC has an annual work plan which is approved by AHMAC. To implement its work plan each year, AMWAC establishes working parties to report on various aspects of the Australian medical workforce.

7.7 20001/02 AMWAC had completed 24 individual workforce reviews, covering around 70% of the specialist workforce. Of these, there have been reviews into 6 sub-specialties in which the College conducts training, namely:

- orthopaedic surgery (1996 and 1999);
- urology (1996)
- general surgery (1996)
- ear, nose and throat surgery (1997); and
- neurosurgery (2000)

**AMWAC approach to workforce planning**

7.8 Generally, AMWAC’s approach to reviewing individual medical disciplines is to access data from existing data bases (eg AIHW, Medicare and Australian Bureau of Statistics) and to collect whatever other information is required for the relevant workforce working party to:

- describe the current workforce (for example, size, characteristics, distribution and service provision) and training program;
- estimate workforce inputs and outputs from retirements, death, migration, immigration and the training program;
- assess the adequacy of the supply and distribution of the current workforce drawing on any international and national benchmarks, the views of the profession

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5 The information contained under this heading is taken from the article titled Medical Workforce Planning in Australia, Australian Medical Workforce Advisory Committee, Australian Health Review (volume 23, No 4, 2000).
and other key stakeholders (such as general practitioners, consumer organisations and government health agencies);

- project workforce supply requirements for the next ten years using a range of needs based and demand based indicators;
- assess the likely impact of new technologies on doctor productivity and future demand for services;
- assess the likelihood of the community deciding to use other providers to provide some of the services currently provided by the respective medical workforce;
- project levels of workforce supply required to meet projected workforce requirements (that is, to achieve a balanced workforce);
- recommend adjustments to training program inputs to achieve a balanced workforce within the ten year planning time frame and to draw attention to any other pertinent issues raised as a result of the review;
- monitor and report to AHMAC on whether supply and requirements are changing as expected, and also that recommendations are being implemented as agreed; and
- at least every five years revisit each workforce and review again.

**AMWAC reviews of surgical sub-specialities**

7.9 A summary of each of the surgical workforce reviews conducted by AMWAC to date is provided below.

*Orthopaedic surgery*[^6]

7.10 AMWAC released an updated report in 1999 on the orthopaedic surgery workforce in Australia, including updated projections of workforce supply requirements until 2009.

7.11 The Commission notes that three of the six members of the orthopaedic surgery working party were surgeons, two being orthopaedic surgeons.

7.12 The original 1996 review of orthopaedic surgery workforce estimated the total practising workforce to be 674, assessed the current workforce as being adequate, but recommended an increase in the number of orthopaedic surgery training positions on the assumption that requirements would grow by an estimated 3% per annum.

7.13 In the 1999 review of orthopaedic surgery, AMWAC estimated the size of the practising orthopaedic surgery workforce in 1998 was 710 (3.8 surgeons per head of 100 000 population or 1:26 240). The majority (63%) of orthopaedic surgeons were aged between 35 and 54 years. 30.2% of orthopaedic surgeons were aged between 45 and 54 years and 20.5% of the workforce was aged between 55 and 64 years. Fourteen per cent of the workforce was aged 65 years and over, which was above the national average for all medical practitioners of 10%.

7.14 AMWAC found that in 1998 there were 117 orthopaedic surgery trainees across the four years of the orthopaedic surgery training program, with the training program graduating between 26 and 30 new orthopaedic surgeons per year. The number of trainees had increased from 1996 in all states except South Australia.

7.15 In assessing the adequacy of the orthopaedic workforce, AMWAC examined the following indicators:

- surgeons-to-population and orthopaedic services per 100 000 population. The Australian Orthopaedic Association suggested that the population catchment required to sustain an orthopaedic surgery service ranged between 22 000 and 30 000;
- public hospital employment vacancies;
- hours worked; and
- elective surgery waiting times.

7.16 Based on these indicators, AMWAC concluded that the orthopaedic surgery workforce was adequate. However, the 1999 review recommended that there be an increase in the number of funded orthopaedic surgery training positions and trainees to match an adjusted expected future growth in requirements over the ten years of 2.7% per year. It recommended that the number of first year orthopaedic surgery trainees should be increased from 33 in 2000, to 44 first year trainees from 2002 onwards. The working party concluded that there should be a staged increase in the number of first year training positions, distributed as set out in Table 7.2 below.

<table>
<thead>
<tr>
<th>State</th>
<th>1998 1st year intake</th>
<th>2001 1st year intake</th>
<th>2002-2005 1st year intake</th>
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</thead>
<tbody>
<tr>
<td>NSW/ACT</td>
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<td>14</td>
<td>15</td>
</tr>
<tr>
<td>VIC</td>
<td>7</td>
<td>10</td>
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</tr>
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<td>QLD</td>
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<tr>
<td>Aust</td>
<td>32</td>
<td>40</td>
<td>44</td>
</tr>
</tbody>
</table>


7.18 The Commission notes that the six member Urology Working Party was comprised of one representative from the College and two from the Urological Society of Australasia.

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7 Ibid, p8.
The report concluded that the urology workforce is adequate. At the time, there were 200 practising urologists and 33 approved training positions throughout Australia. The average age of the urology workforce was 49.7 years. 32.4% of urologists were aged 40 to 49 years, 50.7% aged under 50 years, 18.1% aged over 60 years and 31.2% of urologists were aged in the 50 to 59 year age group. AMWAC also reported that urology surgeons worked an average of 49.8 hours a week.

On balance, the working party concluded that the urology workforce was adequately meeting demand. In particular, the working party found that the Australian specialist urology to population ratio was 1:90 119. In 1995, urology patients made up 9.8% of the national waiting list and the average waiting times in each state and territory for a first urological consultation ranged from 3 to 4.6 weeks. Patients referred with an urgent condition could be seen, on average, within 1.8 to 4.6 days in private rooms and 1 to 12.5 days as public outpatients.

AMWAC estimated that the demand for urological services in hospitals will increase by 46.7% over the next 20 years, mainly due to Australia’s ageing population. It estimated that an average of 9 new urology specialists would enter the workforce each year up to 1996 and 12 would enter the workforce from 1997 to 2001, a growth of 1.4% per annum. The working party concluded that this projected level of graduate output would not be sufficient to meet expected future requirements, which was estimated to grow by 1.6% per annum.

As such, the working party recommended that state and territory health departments undertake negotiations with the Urological Society of Australia for the establishment of additional urological training positions, initially up to 5 by 2001, distributed as set out in Table 7.3.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
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<td>12</td>
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<td>16</td>
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<td><strong>45</strong></td>
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<td><strong>9</strong></td>
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</table>

General/vascular surgery\(^9\)

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AMWAC released a report in 1997 on the general surgery workforce in Australia, including projections of workforce supply requirements to 2007. This report preceded the establishment of vascular surgery as a separate sub-speciality.

The General Surgery Working Party consisted of four surgeons, two representatives from AMWAC and one representative from a state health commission and health department.

Using RACS data, AMWAC reported that in 1996 there was a total of 1225 general/vascular surgeons in Australia. The surgeon-to-population ratio for general and vascular surgeons combined was 1:14 930 and 6.7 surgeons per 100 000 population. The report noted the significant feature of the workforce was the large number of general surgeons aged 55 years and over (38.7%). The vascular surgery workforce was comparatively younger, with 81.2% of the workforce aged under 55 years.

As at June 1996, there were 176 approved general surgery advanced training positions. Between 1989 to 1996 there was a 39% increase in trainee numbers. This varied considerably between the states and territories with a 100% increase in Western Australia and an 18.2% increase in trainees in South Australia. The increase in Western Australia was necessary to bring the state’s trainee numbers to a level appropriate to its population.

The working party examined the following indicators in assessing the adequacy of the general surgery workforce:

- surgeon to population ratio;
- public hospital vacancies;
- elective surgery waiting times;
- waiting times for consultations; and
- surgeons’ perceptions of the adequacy of the current workforce.

The working party concluded that the general/vascular surgery workforce was adequately meeting requirements. In particular, the working party found that surgeon to population ratio had been reasonably constant over the previous 12 years; there were ten general surgery public hospital vacancies and only one vascular surgery vacancy; the waiting times for urgent general surgery were appropriately short; and only 10% of general surgeons felt that more general surgeons were required in their geographic area.

However, the working party considered that an increase in the number of funded general surgery training positions and trainees would be required to match future growth requirements of 1% per year. This would involve increasing the number of graduates from the general surgery training program in 2002 from 42 per year to 52 per year. The report noted that supply trends over the next ten years will be dominated by the large number of surgeons aged 55 years and over and their progression through to retirement. To reach the target of 52 general surgery graduates by 2002, the working party recommended an additional 40 general surgery advanced training positions would be required. It was recommended that this increase be staged and distributed in Table 7.4.
Table 7.4: Number of general surgery training positions recommended by AMWAC

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Total in 1996</th>
<th>Total in 2000</th>
<th>Increase in 1998</th>
<th>Increase in 1999</th>
<th>Increase in 2000</th>
</tr>
</thead>
<tbody>
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<td>75</td>
<td>7</td>
<td>7</td>
<td>3</td>
</tr>
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<tr>
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<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Australia</td>
<td>176</td>
<td>216</td>
<td>16</td>
<td>16</td>
<td>8</td>
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</tbody>
</table>

Neurosurgery

7.30 AMWAC released a report in 2000 on the neurosurgery workforce in Australia, including projections of workforce supply requirements to 2010.

7.31 The Commission notes that there were six members of the Neurosurgery Working Party. In particular, the working party consisted of two surgeons, two representatives from state health departments, a policy officer from AMWAC and a neurosurgery hospital department representative.

7.32 At the time of reporting, the size of the neurosurgery workforce was estimated to be 104. The national neurosurgeon to population ratio was 1:183 763 (or 0.5 neurosurgeons per 100 000 population). In comparison, in Canada the 1996 national neurosurgeon to population ratio was estimated at 1:171 168. The ratio in the United Kingdom in 1996 was 1:500 000 and in 1997 the ratio in the United States was 1:50 000. The average age of neurosurgeons in 1997 was 51.1 years and a total of 41.3% of the workforce was over the age of 55 years. There were very few neurosurgeons under the age of 35 years of age (3.5% of all neurosurgeons). On average, neurosurgeons worked 58.3 hours per week and spent an average of 49.9 of these hour per week on direct patient care.

7.33 The working party found that the neurosurgery workforce is unevenly spread among the states and territories, with NSW/ACT, Queensland and Western Australia being relatively poorly supplied, as compared with their share of the population.

7.34 The working party examined the following indicators in assessing the adequacy of the neurosurgery workforce:

- neurosurgeon to population ratio. The Neurosurgical Society of Australia suggested that ideally there should be at least one neurosurgeon per 175 000 population. The actual national neurosurgeon to population ratio was 1:183 763;

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11Ibid, p57.
• public hospital vacancies;
• waiting times for elective surgery and consultations; and
• perceptions of the adequacy of the current workforce.

7.35 The working party concluded that based on the range of indicators the neurosurgery workforce was adequately meeting requirements. In particular, in May/June 2000 there was only one neurosurgery vacancy within the public hospital system, located in NSW. The median waiting time for neurosurgery was 6 days for urgent patients and 18 days for non-urgent patients. The average waiting time for a standard first consultation with a neurosurgeon in his/her private room was 27.9 days while a patient within the public sector would wait 62.6 days. In addition, 38.5% of surgeons who responded to the AMWAC 2000 survey indicated that they felt that more neurosurgeons were required in their geographic area.

7.36 The working party recommended that in order to achieve an appropriate supply of neurosurgeons, the annual average intake into the neurosurgery training program should be maintained at between 6 and 8 trainees per year from 2001 onwards. By comparison, there were 5 trainees entering in 1998, 6 in 1999 and 9 in 2000. The report recommended that an update of the review of the neurosurgery workforce be undertaken in 2004-2005.

Ear, nose and throat surgery

7.37 AMWAC released a report in 1997 on the ear, nose and throat (ENT) surgery workforce, including projections of workforce supply requirements to 2007.

7.38 The Commission notes that of the nine members of the ENT Working Party, four members were surgeons (three of which being ENT surgeons). The remaining members were health department and AMWAC representatives.

7.39 Medicare data indicated that as at 1995-96 there were 317 ENT surgeons in Australia. Using Medicare data, the ENT surgeon to population ratio was estimated at 1:57 550. The working party also found that the ENT surgeons were older when compared to other specialists. For example, the average age of all male specialists in 1995 was 48.3 years (43.4 for females) while the average age of ENT specialists was 53. In 1995, 40.6% of ENT surgeons were aged 55 years and over and of these surgeons, 41% were aged 65 years and over. 24% of the workforce was aged under 45 years. AMWAC noted that the significant proportion of ENT surgeons aged 55 years and over indicated that there would be a substantial number of surgeons leaving the workforce over the next ten to fifteen years given an average retirement age of 68 years.

7.40 As at June 1997, there were 40 approved ENT surgery advanced training positions in Australia. There were 39 ENT trainees. From 1992 to 1997, there was a 21.2% increase in the number of advanced ENT trainees. The increase varied across the states and territories with a 33.3% increase in Victoria/Tasmania, a 30% increase in NSW and no change in the number of trainees in Queensland, South Australia and Western Australia.

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7.41 While there were no clear benchmarks in relation to the ENT surgeon to population ratio, the working party concluded that the workforce was just satisfactory. However, without prompt corrective action, it concluded that the workforce will move towards a situation of escalating undersupply. In particular, the working party recommended that graduate output be increased from the recent average of 10 graduates per year to 15 graduates per year. To achieve this increase, an additional 20 ENT surgery training positions would need to be established as set out in Table 7.5.

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Total in 1997</th>
<th>Total in 2000</th>
<th>Increase in 1998</th>
<th>Increase in 1999</th>
<th>Increase in 2000</th>
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<tbody>
<tr>
<td>NSW/ACT</td>
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<td>6</td>
<td>4</td>
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</table>

Table 7.5: The number of ear, nose and throat advanced surgical training positions recommended by AMWAC

Cardiothoracic surgery

7.42 AMWAC released a report in 2001 on the cardiothoracic surgery workforce, including projections of workforce supply requirements to 2011.

7.43 The Cardiothoracic Surgery Working Party was comprised of a representative from both the College and the Australasian Society of Cardiac and Thoracic Surgeons, three surgeons (two of which were nominated by state and territory health departments), a consumer nominee as well and an officer from AMWAC.

7.44 AMWAC estimated the size of the cardiothoracic workforce at 107. All cardiothoracic surgeons were located in metropolitan areas. It was noted that cardiothoracic surgery services were generally not sustainable in rural areas due to the infrastructure required to support cardiothoracic surgery and the population base required to maintain a viable cardiothoracic surgery practice. The national cardiothoracic surgeon to population ratio was 1:180 347.

7.45 The average age of cardiothoracic surgeons was 48 years, with a large proportion being less than 45 years of age (39.6%). Only 25.4% of the workforce were aged 55 years or older. In 1998, medical labour force data showed that, on average, cardiothoracic surgeons worked 64.1 hours per week, which was among the highest of any medical specialist workforce.

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The working party concluded that the cardiothoracic surgery workforce was adequately meeting requirements. In order to achieve an appropriate supply of cardiothoracic surgeons, the report recommended that an intake to the cardiothoracic surgery training program should be maintained at approximately 5 per year.

Implementation of AMWAC recommendations

As mentioned previously, AMWAC monitors progress on implementing its targets for the number of medical trainees and reports annually on this to AHMAC and the AHMC.

In its 2001-02 Annual Report, AMWAC reported that overall implementation of AMWAC recommendations is mainly on schedule. Of the reviews that have been completed for surgical specialities, ENT surgery and orthopaedic surgery continue to make slow progress with implementing recommendations. Specifically, for ENT surgery only six new training positions have been created since 1997, which is well short of the recommended target of 20 new training positions by 2000. In orthopaedic surgery there were 37 first year advanced trainees in 2002, which is short of the recommended target of 40 first year trainees by 2001. Generally, AMWAC reports that slow implementation of AMWAC recommendations appears to be ‘due to funding and training infrastructure difficulties’.

A summary of the progress in implementing the AMWAC recommendations in each of the relevant surgical specialities for 2002 is provided below:

<table>
<thead>
<tr>
<th>Surgical specialty (and year of AMWAC review)</th>
<th>State/territory</th>
<th>AMWAC recommendation</th>
<th>Implementation</th>
<th>Whether AMWAC recommendation met</th>
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<td></td>
</tr>
</tbody>
</table>

Table 7.6: Implementation of AMWAC recommendations in surgical sub-specialities

<table>
<thead>
<tr>
<th>Surgical specialty (and year of AMWAC review)</th>
<th>State/territory</th>
<th>AMWAC recommendation</th>
<th>Implementation</th>
<th>Whether AMWAC recommendation met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery (2000)</td>
<td>NSW/ACT</td>
<td>15</td>
<td>NSW-16; ACT-1</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Vic</td>
<td>10</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Qld</td>
<td>8</td>
<td>8</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>SA/NT</td>
<td>3</td>
<td>SA-3</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>WA</td>
<td>4</td>
<td>5</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Tas</td>
<td>1</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>41</strong></td>
<td><strong>45</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

**Recommended number of first year advanced trainees**

Neurosurgery (2000)

Recommended number of first year advanced trainees: 6 to 8 each year between 2001 and 2010.

Number of first year advanced trainees in 2002: 6. Yes.

Cardiothoracic Surgery (2001)

Recommended number of first year advanced trainees: 5 each year between 2001 and 2011.

Number of first year advanced trainees in 2001: 6. Yes.

Ear, Nose and Throat Surgery (1997)

Recommended total number of training positions by 2000.

Total number of training positions in 2002:

<table>
<thead>
<tr>
<th>State/territory</th>
<th>AMWAC recommendation</th>
<th>Implementation</th>
<th>Whether AMWAC recommendation met</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW/ACT</td>
<td>21</td>
<td>NSW-15</td>
<td>No</td>
</tr>
<tr>
<td>Vic/Tas</td>
<td>16</td>
<td>Vic-13</td>
<td>No</td>
</tr>
<tr>
<td>Qld</td>
<td>11</td>
<td>9</td>
<td>No</td>
</tr>
<tr>
<td>SA/NT</td>
<td>6</td>
<td>SA-7</td>
<td>Yes</td>
</tr>
<tr>
<td>WA</td>
<td>6</td>
<td>5</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>48</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

ACCC submission to 2001 Review of AMWAC

7.50 In February 2000, the Australian Health Ministers’ Advisory Council (AHMAC) agreed to conduct the first five-year review of AMWAC. The review of AMWAC and its operations commenced in 2001. Broadly, the review examined AMWAC’s performance against AMWAC’s terms of reference.

7.51 The Commission provided a submission to the review in September 2001. The following two reports prepared by for the Commission by Professor Jeff Borland of the University of Melbourne were attached to the submission:

- An evaluation of the AMWAC 1999 review of the orthopaedic surgery workforce in Australia; and

- Recommendations on the AMWAC process for the provision of advice on medical workforce matters.

7.52 In its submission to the review, the Commission, among other things:

- noted Professor Borland’s conclusion that while the overall methodology applied by AMWAC appears satisfactory, there are deficiencies and lack of rigour in the detail of its implementation. The Commission expressed concern that this has
affected the various conclusions contained in AMWAC reviews, and may have caused workforce needs and required training positions to be systematically under-estimated. The Commission supported recommendations made by Professor Borland on this issue; and

- agreed with Professor Borland’s recommendation that AMWAC working parties should contain appropriately qualified persons in economics and quantitative methods. In addition, the Commission submitted that these persons should be sufficiently senior and recognised in their field to have the ability to counterbalance the influence of the members of the profession.

7.53 In an additional submission to the review, the Commission suggested, as a matter of priority, that AMWAC undertake a review of the current adequacy of supply of specialist medical services, particularly in the specialist surgical area.

7.54 More generally, the Commission also submitted that a major issue for a body such as AMWAC is to assess whether supply is adequate, both currently and for the future.

Outcome of the AMWAC review

7.55 The AMWAC review team completed its report in early 2002. Key recommendations included:

- that AMWAC be retained;

- that AHMAC commend AMWAC on its achievements;

- to enhance the objectivity, relevance and robustness of AMWAC recommendations, that AMWAC working parties include stronger input from economic and statistical experts, government jurisdictions and consumers. In addition, AMWAC should establish guidelines regarding membership of working parties and consultation processes, and establish a reference panel including expert clinicians, representatives of consumer organisations and health service managers, to be drawn on for participation in AMWAC working parties;

- that AMWAC, in preparing its workforce reports, should consider evidence in several specified crucial areas including: consumer expectations (eg access, consumer trends); demographic (eg changing population, rural issues); economic (eg changes in health insurance coverage and utilisation, effect of the Australian dollar on the supply of overseas-trained doctors, changes in medical indemnity); medical workforce (eg full-time versus part-time work, implications of decisions on safe working hours, gender distribution, use of overseas-trained doctors, changes in training); general health system (eg impact of shortages in nursing and allied health, health delivery and patient practice); epidemiological (eg changing disease patterns, Aboriginal and Torres Strait Islander health issues); and international considerations (eg migration policy);

- that AMWAC should include advice in its reports on possible approaches to achieving desirable workforce supply in accordance with quality health care practices, including increasing training numbers, addressing maldistribution, importing additional practitioners and possible workforce substitution;

- that AMWAC should review its methodology and revise its reporting to take into
account issues raised in submissions to the review, specifically including the Borland reports lodged by the Commission; and

- that AMWAC should take into account quantitative and qualitative education, training and supply issues when conducting specific workforce studies, including: changing public hospital practices, trends in career choices by doctors, technology changes, the role of the private sector, changes in undergraduate and specialist education.

7.56 The review team also noted that the implementation of AMWAC recommendations was an area of particular concern, and one where far better co-ordination is required, including clarification of roles and responsibilities. While confirming that the implementation of AMWAC recommendations is not the responsibility of AMWAC, the review team considered that AMWAC should provide advice to those responsible on possible approaches to implementation for consideration by those responsible for implementation (that is, Commonwealth, state and territory governments, specialist colleges and the higher education sector). It also concluded that AHMAC should determine the appropriate implementation mechanisms, including accountabilities and reporting requirements.

7.57 The review team also proposed revised terms of reference for AMWAC, including:
- to provide advice to AHMAC on a range of medical workforce matters;
- to develop models for describing and predicting future medical workforce requirements and provide advice on its methodology, including indicators and benchmarks, for use by the employing and workforce controlling bodies including governments, specialist colleges and tertiary institutions;
- to oversee the establishment and development of data collections concerned with the medical workforce, and analyse and report on those data to assist workforce planning;
- to work in coordination and cooperation with the Australian Health Workforce Officials’ Committee in the assessment of broader health human resources planning requirements;
- to provide AHMAC with advice as requested on best practice models of care, future service delivery developments and dynamic scenario planning for the medical workforce;
- to take information on evidence-based practice and outcomes into account in its planning and provide advice in this in its reports; and
- to advise AHMAC on possible approaches to achieving desirable workforce supply in accordance with quality health care practices.

**Government response to AMWAC review**

7.58 At its May 2002 meeting, AHMAC accepted the recommendations contained in the final report entitled *Tomorrow’s Doctors – Review of the Australian Medical Workforce Advisory Committee.*
8. THE IMPLEMENTATION OF AMWAC TARGETS – ROLE OF STATE AND TERRITORY GOVERNMENTS

8.1 As noted in previous chapters, surgical training in Australia occurs largely in public hospitals. There are three major requirements for establishing a surgical training position in the Australian public health system:

- the provision of sufficient state and territory government funding;
- the agreement of the relevant medical college to accredit the training position or training program. This process is discussed in Chapter 6 and
- the establishment of the position in the hospital or other training institution.

Funding of surgical training positions

8.2 The establishment of surgical training positions in public hospitals requires not only funding for the salary of the trainee plus on-costs, but also sufficient funding to ensure that the College’s accreditation criteria are met generally; for example, as regards advanced surgical training positions, that the public hospital provides:

- an appropriate case load and case mix (ie of patients);
- an adequate laboratory service;
- access to an appropriate number of autopsies;
- access to appropriate information technology equipment;
- an adequate diagnostic radiology department;
- an emergency accident service with 24 hours resident medical officer cover;
- a comprehensive outpatient clinic;
- adequate personal operative experience for the trainee under surgical supervision; and
- a medical reference library.

8.3 The Minister for Health in Western Australia, the Hon Bob Kucera APM MLA estimated that approximately $100,000 per annum is necessary to cover a trainee’s salary and on-costs. Queensland Health estimated that funding of approximately $97,000 plus 23% for on-costs is required for salaries of a new training position. Queensland Health further noted other costs such as additional infrastructure, equipment, nursing and allied health may add significantly to this cost. Queensland Health estimated that the total costs could be in the vicinity of $1,000,000 to $2,000,000 depending on the sub-speciality.

18 Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submission to the Commission, 18 September 2002.
19 Queensland Health submission to the Commission, 24 September 2001, p1.
Sources of funding

8.4 The Commonwealth and state and territory governments each provide approximately 50 per cent of public hospital funding.20

8.5 Commonwealth funding is provided to the states and territories specifically for public hospitals in accordance with Australian Health Care Agreements between the Commonwealth and each state and territory. Current agreements run from 1 July 1998 to 30 June 2003.

8.6 The Agreements are built upon the Health Care Agreement Principles, which are enshrined in the Health Care (Appropriation) Act 1998. These principles are that public hospital services must be provided free of charge to public patients, that access to these services must be on the basis of clinical need and within a clinically appropriate period, and that people should have equitable access to public hospital services regardless of their geographical location.

Allocation of funding by states and territories to medical training posts in public hospitals

8.7 In almost all states and territories, it appears that funding for medical training posts in public hospitals is drawn from general budget allocations to public hospitals (or area health services); that is, no specific funding is provided for medical training posts.

8.8 NSW Health submitted that:

Funding for [surgical training] positions is usually drawn from the general hospital budget. There is no special purpose grant for funding of surgical training positions in NSW apart from some special purpose funding for some rural training posts.21

8.9 Queensland Health advised that funding for new and existing training posts is drawn by public hospitals from their general budget allocations.22 The Commission understands that Queensland public hospitals are formally part of Queensland Health. Consequently, their budget allocation is part of Queensland Health’s budget allocation.

8.10 The Health Department of Western Australia advised that funding for training positions is drawn by hospitals from the allocation from their general budget allocation, with no specific allocation for training positions.23

8.11 The Tasmanian Department of Human Services submitted that:

The Department has a global budget allocation, and the final determination of the number, location and funding of new training posts does not normally involve specific consideration of the case by the Minister or Government.24

8.12 The ACT Department of Health, Housing and Community care advised that it does not provide funding specifically for new training posts. Training programs are filled from the budgets of the relevant clinical departments within ACT hospitals. A

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21 NSW Health submission to the Commission, April 2002, p7.
22 Queensland Health submission to the Commission, 24 September 2001, p2.
23 Health Department of Western Australia, verbal submission to the Commission, 30 August 2001.
24 Tasmanian Department of Human Services submission to the Commission, 27 August 2001, p2.
proportion of these funds is allocated to training and development, but it is for the hospital to determine what types of training and development this funding is allocated to. The Department noted that levels of actual spending on training and development are difficult to determine as much of the spending is interwoven with other hospital activities.\(^{25}\)

8.13 On the other hand, the Victorian Minister for Health, the Hon John Thwaites MP, submitted that:

Medical specialist training is heavily subsidised by State training and development grant funding (currently totally approximately $36m per annum) paid to public hospitals for trainee and clinical academic positions. State training and development funding however does not fund all accredited vocational training positions around the state, and where such funding is provided, it is a contribution to salary costs (ranging from 75\% of base salary for Hospital Medical Officers Year 6, when vocational training commences, to 54\% of base salary for Registrars). The total number of positions attracting the central subsidy is generally guided by recommendations on training numbers provided AMWAC.

Hospitals, in consultation with medical staff and consultants can and do provide vocational training positions beyond those that attract the central subsidy. The salaries for these positions are funded from the hospitals’ general revenue streams and would be based on an assessment that there was sufficient workload to sustain additional positions.\(^{26}\)

8.14 The Victorian Department of Human Services added that:

it seeks to provide the state-wide public hospital system with funding for a number of surgical trainee posts in observance of the recommendations of AMWAC.\(^{27}\)

**Issue: how AMWAC targets are implemented**

8.15 The Victorian Minister for Health, the Hon John Thwaites MP, submitted that in Victoria

the establishment and accreditation of training positions is a matter of direct negotiation between the colleges and each hospital.\(^{28}\)

8.16 Mr Thwaites also submitted that:

The state plays a substantial role in funding and, increasingly, in planning medical specialist training positions. In relation to medical workforce planning, as well as facilitating implementation of AMWAC recommendations, Victoria is undertaking state based workforce planning studies to identify and respond to issues including supply and distribution.\(^{29}\)

8.17 NSW Health submitted that in NSW the accreditation process can be summarised as follows:

- Advanced surgical training positions are usually initially established as “unaccredited” (service) positions.

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\(^{25}\) ACT Department of Health, Housing and Community Care verbal submission to the Commission, 13 September 2001, p2.
\(^{26}\) Victorian Minister for Health, the Hon John Thwaites MP, submission to the Commission, 30 September 2002, pp1,2.
\(^{27}\) Victorian Department of Human Services submission to the Commission, 18 January 2002 p1.
\(^{28}\) Victorian Minister for Health, the Hon John Thwaites MP, submission to the Commission, 30 September 2002 p2.
\(^{29}\) Ibid, p1.
• A decision is made locally to apply for accreditation where the hospital considers that there is a good prospect of achieving accreditation.

• The accreditation process requires extensive documentation and a formal survey. The documentation is prepared with input from the relevant Department of Surgery, the hospital administration and the Area Health Service.

... 

• The total number of surgical positions (accredited and unaccredited) is determined by the area health service.30

8.18 Queensland Health submitted that:

The identification of new training posts is the responsibility of the Department in consultation with individual hospitals. This is a top down bottom up approach whereby Hospitals/Department Heads/College representatives will at times initiate the creation of training positions in some specialities.

New training posts are identified using AMWAC benchmarks and service needs.

On identifying a need for a training position, the Department (usually the hospital Medical Superintendent) would ask the College to undertake an accreditation visit.31

8.19 Queensland Health further submitted that:

funding is inextricably linked to accreditation of training posts. There is no point, for example, providing funding for a training post if accreditation cannot be obtained.32

8.20 The Commission understands that ‘funding’ in this statement refers salaries and on-costs.

8.21 The Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submitted that:

potential higher surgical training [HST] posts may be identified by a hospital or health service or alternatively by the RACS. Hospitals or health services that consider they have the capacity to support a HST post are able to submit an application to RACS for an accredited training post. The RACS may if they consider a hospital or health service to have the capacity to support a HST post, initiate contact with this organisation to lobby for additional training posts.33

8.22 Mr Kucera also submitted that:

the number of trainees throughout Australia and in each state and territory is determined by AMWAC. On the basis of this information, the RACS identifies suitable training posts. The Department of Health then has to determine whether there are sufficient funds available within the state health budget to meet the cost of these posts.34

8.23 Again, the Commission understands that the reference to the ‘cost’ of training posts is a reference to salaries and on-costs.

30 NSW Health submission to the Commission, April 2002, p7.
31 Queensland Health submission to the Commission, 24 September 2001, p1.
32 Queensland Health submission to the Commission, 4 May 2001, p4.
33 Western Australian Minister for Health, the Hon Bob Kucera APM MLA, submission to the Commission, 18 September 2002, p1.
34 Ibid, p2.
8.24 The Tasmanian Department of Health and Human Services submitted that:

the hospitals which are engaged in specialist training in various disciplines are primarily responsible for identifying potential new training posts. Those hospitals are directly responsible to the Department’s Director Hospitals and Ambulance, through the hospital CEO. There are no hospital boards or area health services. In practical terms, there is no distinction between the terminology ‘department’ or ‘hospitals’.

A decision to identify a new training post is therefore a joint decision of the Department’s Hospitals and Ambulance Service Executive Committee and both need and cost considerations are important factors in reaching the decision.

The Tasmanian section of the relevant college would also normally be consulted in identifying and requesting approval for a new training post.

Cost considerations, in particular the salary and on-costs of training posts, but also related infrastructure costs, are of fundamental importance in deciding whether a new training post will be established. An AMWAC recommendation for a new training post also has a very strong influence on the relative merits of that proposed post against other possible training or service influenced posts.35

8.25 The ACT Department of Health, Housing and Community Care advised that responsibility for identifying new training posts in the ACT rests with individual hospitals – specifically, clinical departments within hospitals identify potential training posts.36

35 Tasmanian Department of Human Services submission to the Commission, 27 August 2001, p2.
36ACT Department of Health, Housing and Community Care verbal submission to the Commission, 13 September 2001, p1.
9. PUBLIC BENEFIT TEST

9.1 The Act provides that the Commission may only grant authorisation where the public benefit test in section 90 of the Act is satisfied.

9.2 While section 90 contains three minor variations of the public benefit test, the Commission adopts the view taken by the Trade Practices Tribunal (now the Australian Competition Tribunal) that in practice the tests are essentially the same.\(^{37}\)

9.3 In this case, the College has applied under sub-section 88(1) of the Act and the Competition Codes of each state and territory to give effect to arrangements that have the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

9.4 The relevant formulation of the public test is therefore found in sub-section 90(7) of the Act, which provides that the Commission shall not grant such an application unless it is satisfied in all the circumstances:

- that the arrangement has resulted, or is likely to result, in a benefit to the public (the public benefit); and

- that this benefit outweighs or would outweigh the detriment to the public constituted by any lessening of competition that has resulted, or is likely to result, from giving effect to the arrangements (the anti-competitive detriment).

9.5 The Commission therefore must examine the likely public detriment from any anti-competitive effect of the arrangements as well as the likely benefit to the public arising from the arrangements and weigh the two to determine which is greater. Should the likely benefit outweigh the likely anti-competitive detriment, the Commission may grant authorisation. If not, the authorisation may be denied. However, section 91(3) of the Act allows the Commission to grant authorisation subject to conditions that ensure that the public benefit outweighs the anti-competitive detriment.

**Definition of public benefit and anti-competitive detriment**

9.6 Public benefit is not defined by the Act. However, the Australian Competition Tribunal has stated that the term should be given its widest possible meaning. In particular, it includes:

- anything of value to the community generally, any contribution to the aims pursued by society including as one of its principle elements … the achievement of the economic goals of efficiency and progress.\(^{38}\)

9.7 Similarly, anti-competitive detriment is not defined in the Act but the Tribunal has given the concept a wide ambit. It has stated that the detriment to the public constituted by a lessening of competition includes:

- any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency...\(^{39}\)

\(^{37}\) *Re Media Council of Australia (No. 2)(1987) ATPR 40–774 at 48,419.*

\(^{38}\) *Victorian Newsagency (1994) ATPR 41–357 at 42,677.*

\(^{39}\) *Victorian Newsagency(1994) ATPR 41–357 at 42,683.*
Future with-and-without test

9.8 The Commission also uses the ‘future with-and-without test’ established by the Australian Competition Tribunal to identify and measure the public benefit and anti-competitive detriment generated by arrangements proposed to be authorised.40

9.9 Under this test, the Commission compares the public benefit and anti-competitive detriment generated by arrangements in the future if the authorisation is granted with those generated if the authorisation is not granted. This requires the Commission to make a reasonable forecast about how the relevant markets will react if authorisation is not granted. This forecast is referred to as the counterfactual.

Market evaluation

9.10 The Commission identifies and measures the public benefit and anti-competitive detriment generated by arrangements for which authorisation is sought in the relevant markets. This requires the relevant markets to be defined.

9.11 Section 4E of the Trade Practices Act states that a market for goods or services includes other goods or services that are substitutable for, or otherwise competitive with, the first goods or services.

9.12 In establishing a market’s boundaries, the Commission seeks to include:

- all those sources of the product or closely substitutable products to which consumers would turn in the event that the firms currently supplying them attempt to raise the price of the product; and
- all potential consumers of a product to which suppliers would turn if they cannot obtain an adequate price for this product from their current consumers, as well as all consumers of products suppliers can readily supply in place of this product.

9.13 The Commission may define up to four different dimensions of a market. These are:

- the geographic dimension – this may be local, state, national or international depending on where trade occurs;
- the product dimension – this will depend on whether products are close substitutes for one another;
- the functional dimension – this requires, where relevant, the identification of appropriate stages of production and distribution (for example, the delineation of retail and wholesale markets); and
- the time dimension – where relevant, this refers to the time period over which substitution possibilities should be considered.

9.14 Generally, if market boundaries are defined to narrowly so that actual or potential sources of competition are excluded then the proposed conduct will appear to generate greater anti-competitive detriment than is actually the case. On the other hand, the market may be defined too widely to, for example, inappropriately include certain

40 See, for example, Re Australasian Performing Rights Association (1999) ATPR 41-701.
products or geographic areas. In such circumstances the anti-competitive detriment of
the proposed conduct will appear to be weaker than it actually is.

9.15 Depending on the circumstances, the Commission may not need to comprehensively
define the relevant markets to undertake a public benefit analysis. In particular, it
may not need to precisely delineate or delineate at all one or more of the four market
dimensions. For example, it may be apparent that a net public benefit will or will not
arise regardless of this definition. Therefore, in the authorisation context, it is only
necessary for the Commission to delineate the relevant market to the extent needed to
asses the public benefits and detriments of the proposed conduct.

Whether arrangements breach the Act

9.16 As indicated above, the College’s application seeks to give effect to arrangements
which have the purpose, or have or may have the effect, of substantially lessening
competition within the meaning of section 45 of the Act.

9.17 However, in assessing an application for authorisation, the Commission is not
required to form a view about whether the College’s arrangements breach section 45.
It is only required to determine whether the public benefit test has been satisfied.

Term of authorisation

9.18 Section 91(1) of the Act allows the Commission to grant authorisation for a specific
period of time. The Commission’s usual practice is to make use of this provision so
as to provide it with an opportunity to review authorisations in the light of any
changed circumstances. The period for which the Commission grants authorisation
will depend on the specific circumstances of each case.

9.19 The Commission may also authorise different aspects of conduct for which
authorisation is sought for different periods.41

10. THE COLLEGE’S SUPPORTING SUBMISSION

Public Benefits

10.1 The College argues that the arrangements for which authorisation is sought produce the following public benefits.

<table>
<thead>
<tr>
<th>Maintenance of high standards of surgical practice, the protection of public health and safety and the maintenance of public confidence</th>
</tr>
</thead>
</table>

10.2 The College contends that it conducts a comprehensive selection, training, examination, accreditation and assessment program in order to maintain high standards of surgical services which in turn ensures that trainees become safe and competent surgeons. The comprehensive nature of the arrangements protects public health and safety and maintains public confidence in surgical services as well as the health care industry as a whole.

10.3 The College states that all of its programs are up-dated and enhanced to take account of international developments and to ensure they accordin ‘international best practice.’ Further, the high standards of surgical practice in Australasia are recognised in the international community.

10.4 The College argues its reputation and standing, and the continuation of its work is also a public benefit as it ensures that surgeons will continue to be trained to the highest standards.

10.5 In particular, the College contends that the rationale behind the comprehensive accreditation process in place for the basic and advanced surgical training programs is that:

- it is crucial for maintaining high standards of surgical services to ensure that hospital posts are sufficiently and appropriately supported and supervised so trainees can receive comprehensive training and guidance; and
- several posts are required to obtain sufficiently wide experience.

10.6 The College further contends that it is essential that there is a consistently high standard amongst all doctors, both locally and overseas trained. Consequently, there must also be a comprehensive assessment procedure for overseas trained practitioners.

<table>
<thead>
<tr>
<th>Economic efficiency and cost savings to the public</th>
</tr>
</thead>
</table>

10.7 The College noted that, given Australia’s ageing population, it is especially important that high standards of surgical services are maintained at the lowest possible cost to the public because:

- the demands of the elderly on health care systems are much greater than those of the young; and
- an ageing population increases the ratio of the number of people outside the labour force to those inside it.
10.8 In a predominantly tax funded health care system, such as Australia’s, these two factors means that a declining proportion of the population is contributing to the costs of health care, even as those costs are rising.

10.9 The College contends that it makes a significant contribution to containing health care costs because:

- it is a non-profit organisation; and
- does not receive any government funding directly for selection, training, examination, accreditation, education and continuing professional development.

10.10 It adds that the only costs incurred by the public from the College’s activities are generated through government funding of hospital posts and the administration of rural training schemes.

10.11 The College argues that its Fellows supply their services to the selection, training and examination programs free of charge (while trainees do pay fees, these cover administrative, educational development, examination etc costs).

10.12 The College estimates that, conservatively, this pro-bono work by Fellows saves the community a minimum of $230 million per annum, in addition to capital costs of some $70m associated with conducting the College’s programs. Table 10.1 sets out how the College has calculated this estimate.

<table>
<thead>
<tr>
<th>Table 10.1: calculation of the value of the College’s pro-bono work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECURRENT COSTS – EDUCATION AND TRAINING</strong></td>
</tr>
<tr>
<td><strong>Skills course</strong></td>
</tr>
<tr>
<td>1. Fellows time</td>
</tr>
<tr>
<td>- EMST 441 000</td>
</tr>
<tr>
<td>- CCrISP 756 000</td>
</tr>
<tr>
<td>- BSS 378 000</td>
</tr>
<tr>
<td>2. Equipment (donations) 50 000</td>
</tr>
<tr>
<td>3. Administration and Capital (refer below) 1 575 000</td>
</tr>
<tr>
<td><strong>Training and Supervision of Trainees</strong></td>
</tr>
<tr>
<td>1. Fellows time 216 000 000</td>
</tr>
<tr>
<td>(1500 trainees x 30 hrs supervision per week x 48 weeks x $100 per hour)</td>
</tr>
</tbody>
</table>
2. Administration and Capital (refer below)

Examinations
1. Fellows time
   Part 1 Exam:
   MCQ (6 days x 30 Fellows x $1500 per day) 270 000
   OSCE (6 days x 120 Fellows x $1500 per day) 1 080 000
   Part 2:
   (7 days x 135 Fellows x $1500 per day) 1 417 500
2. Administration and capital (refer below)

Overseas trained doctor assessments
1. Fellows time
   (80 applications x 2 days x $1500 per day) 240 000
2. Administration and capital (refer below)

Curriculum materials development
1. Contracts (Distance Learning Program) 750 000
2. Fellows time (22 modules x 5 days x $1500) 495 000

Educational Committees (CIC Committee, Speciality Boards, Board of CPD)
1. Fellows time (3 days x 150 Fellows x $1500 per day) 675 000
2. Administration and capital (refer below)

RECURRENT COSTS – INFRASTRUCTURE

Operational budget
(Total College budget - $14m)
Salaries
Consumables
Travel and accommodation
Utilities
Minor equipment
10 500 000

CAPITAL COSTS

Buildings and plant
(Total College assets - $27m)
Skills centres (3) 47 250 000
20 250 000
TOTAL – FELLOWS TIME 221 752 500
GRAND TOTAL 300 552 500

Source: College submission to the ACCC, 30 March 2001, Attachment 11.

10.13 In calculating this, the College states that only costs which are directly attributable to the education and training programs of the College have been taken into account. The College also notes that the hourly rate used to calculate the value of the training provided by surgeons – $100 – is likely to be lower than the market rate that would be charged by surgeons for their services, particularly given that the more experienced and senior surgeons tend to provide training.

10.14 The College adds that beyond the costs savings and the amount of time spent by a fellow with a trainee is the patience, tolerance and skill required to train
trainees. The College states that while some training takes place in low risk environments, for example, through the use of simulators, fellows must also be vigilant and attentive to trainees in order to ensure early error recognition and recovery.

### Consequence of the College ceasing the conduct sought to be authorised

**10.15** The College states that currently it is the sole body in Australasia training surgeons in the nine surgical sub-specialties. It argues that, if it were to cease undertaking the arrangements for which authorisation is sought, a new entity (or entities) would have to be created to undertake them. This new entity would need to develop programs to ensure the same high standard of surgical service is maintained.

**10.16** The College argues that this new entity would need to recruit qualified surgeons, as the skills and attributes of a safe and competent surgeon can only be learned by a trainee watching, participating and progressively doing what a surgeon does under the tuition of other surgeons.

**10.17** The College contends that surgeons may choose not to become involved in training if they were paid to provide it, as introducing payments would undermine the professional ethos that surgeons consider underpins their training of surgical registrars. Ultimately, the cost to the taxpayer of the new entity would equal the value of the pro-bono work provided by surgeons under the current system – that is, at least $230 million per annum.

**10.18** The College adds that it is not only the cost but the time and effort required, the dislocation of training new surgeons and the uncertain effectiveness of any new system which must be taken into account.

**10.19** The College concludes that establishing a new system is clearly not the most efficient use of society’s resources.

### Other public benefits

**10.20** The College argued that its activities more generally give rise to many public benefits. For example, the College provides for the ongoing retraining and professional development of Fellows through its continuing professional development program. The College and its Fellows also continue to work free of charge on a number of public safety and health initiatives as well as running outreach programs delivering essential surgical services to remote areas within Australian as well as overseas.

### Anti competitive detriment

**10.21** The College contends that it has no ability to limit the number of persons entering the surgical profession. It is only able to select and train as many suitably qualified doctors as there are funded and accredited posts in hospitals. It aims to fill all such training posts.

**10.22** The College states that decisions to fund hospital training posts are made by state and territory governments and by hospitals. It adds that, in special circumstances, the Federal Government may also have a significant role (e.g. by funding rural posts).
The College states that in 2001 it identified five orthopaedic posts for accreditation that were not eventually funded.

10.23 While the College accredits training posts, it does this to ensure hospitals meet training requirements and educational standards.

10.24 The College states that shortages of hospital beds and reduced theatre schedules hamper its ability to train surgeons. It notes that, in his report into surgical services in Australia (see paragraph 1.23), Professor Peter Baume found that shortages in hospital facilities and services impact directly and immediately upon the capacity of surgeons to train other surgeons.

10.25 For example, the College understands that at Monash Medical Centre there is a waiting list of 2,500 orthopaedic patients. There are 15 orthopaedic surgeons, but they are under-employed because reduced theatre schedules mean that available operating theatre hours are exhausted by emergency cases or non-elective surgery.

10.26 The College contends that while surgeons in a large capital city can probably find work in other hospitals, in rural areas, such as Lismore, the same lack of beds and operating theatres has led to surgeons to leave the area. The College argues that if the number of surgeons falls, the hospital may no longer be suitable as a training centre and this in turn has an impact on trainee numbers in particular sub-specialties.

10.27 The College argues that its role in relation to the placing of overseas trained practitioners is a recommendatory one only, and that decision-makers do not have to follow the College’s recommendations.

10.28 The College states that it receives approximately 100 applications a year and almost all applicants ultimately receive a recommendation. The range of possible recommendations is set out at paragraph 6.120.

10.29 The College states that:

- the absolute limit on candidates for surgical training is the number of entrants to medical school;
- the Federal Government’s limitation on the number of Medicare provider numbers awarded to medical graduates further reduces the number of potential trainees as a trainee cannot be awarded a post without a provider number;
- it is not always able to fill all available posts because not every doctor wishes to pursue a career in a particular specialty. For example, in 2001 the College was unable to fill all available neurosurgery posts because not enough suitably qualified people applied; and
- the number of training places is influenced by AMWAC recommendations to health ministers. The College notes that the number of surgeons it trains is substantially similar to the number recommended by AMWAC.

**Conclusion**

10.30 The College concludes that the arrangements for which it seeks authorisation confer extensive and significant public benefits which outweigh any possible anti-competitive detriment. It also re-affirms its view that none of its activities raise
concerns under the TPA.

Other issues

The market for surgical services

(a) The product market

10.31 There are nine recognised surgical sub-specialties: general surgery; neurosurgery; otolaryngology – head and neck surgery; plastic and reconstructive surgery; vascular surgery; cardiothoracic surgery; orthopaedic surgery; paediatric surgery; and urology.

10.32 However, the College submits that the unique features of the surgical profession make it extremely difficult to define a market or series of markets. In particular, it submits that, rather than a series of separate markets for surgical sub-specialties, there are a series of sub-markets within the markets for surgical services. In particular, it highlights that:

• surgeons often choose, for personal interest reasons, to specialise in part of the specialty in which they were trained. Further, surgeons may change their area of sub-specialisation over time. Consequently, the skills of surgeons who notionally practise in the same specialty may not be substitutable;

• there are significant overlaps between different sub-specialties. For example, hand surgery can be performed by plastic and reconstructive surgeons, orthopaedic surgeons and general surgeons. Consequently, the skills of surgeons who are notionally in different sub-specialties may in some cases be substitutable; and

• the public perception is that the relevant market is one for surgery.

10.33 The College concludes that the relevant product markets are likely to be the markets for specialist surgical services and that, within each of these markets, there are a series of sub-markets where there is, in many cases, significant overlap at the margins.

(b) The geographical market

10.34 The College highlights that

• doctors are registered to practise in the state or territory in which they live and work;

• employment opportunities for surgeons are largely available on the basis of funding decisions made by state and territory governments and the relevant hospitals;

• patients will generally travel to the major metropolitan centres within each state to seek treatment;

• while there is been substantial movement of surgeons between states, particularly in their early years, this does not outweigh the factors above such that there is a national market.

10.35 Ultimately, the College submits that the relevant markets are the state-based markets for specialist surgeons.
Competition between surgeons

10.36 The College submits that there is significant competition between the surgeons in the various sub-specialties. At all times, however, surgeons are conscious of the ethical constraints they must work under.

10.37 The College highlighted that surgeons mainly compete with each other by gaining strong professional reputations such that cases are referred to them.

10.38 The College does not have detailed information as to the price competition that may occur between surgeons. However, it submits that, given that human life is at stake or patients are concerned with the carrying out of operations that will give them a better quality of life, price competition is of less significance for surgeons than it may be in other professions.

10.39 However, the College states that, in private hospitals, surgeons generally charge within 15% of the Medicare rebate and, to this extent, they compete on price. The College also notes that, as individual surgeons are likely to work in both the public and private hospital systems, they could be regarded as competing with themselves on price when surgeons accede to their patient’s wish that they be treated in a public hospital.

Supplier-induced demand for medical services

10.40 The College has no firm view as to whether the theory of supplier-induced demand is correct.

10.41 The College also notes that government considers that a limitation on the number of doctors generally will generate cost savings. In particular, the College argues that the government, in making funding decisions, and AMWAC, in making recommendations, are influenced by the theory of supplier-induced demand. It notes that, in its Report into the Health Insurance Amendment Bill (No 2) 1996, the Senate Community Affairs Legislation Committee recognised that:

There is widespread agreement that the increasing number of medical practitioners is one of the main growth pressures on the health costs in Australia.42

10.42 The College argues that the government’s role in funding suitable hospital places and its approach to holding down costs by limiting the number of doctors, means that the College, subject to its lobbying efforts, can only train as many surgeons as there are places. The College stated that it is therefore arguable that public benefits, in terms of cost savings, maintaining the reputations of practitioners, and encouraging the best and brightest to pursue medical careers, are not generated by opening the surgical services market to anyone who may wish to pursue a career in surgery.

10.43 The College also argues that as Australia’s health care sector is largely funded by Medicare, the normal constraints that the price of services place upon consumers’ demand are distorted. With bulk billing readily available for many services, patients are able to ‘doctor shop’ at no cost to themselves and seek medical services which they may have otherwise foregone.

10.44 The College argues that this pricing distortion has led to the problem of over-servicing in some areas of the health care industry. It further contends that the pricing distortion in medical services must be taken into account in any economic analysis.

Market based approaches to the health care sector

10.45 The College submits that a strict market based approach is incompatible with both health care and the training of surgeons. Further, the market’s operation cannot be paramount in an area of the economy that is concerned with matters of life and death.

10.46 The College agrees with the views of Paul Komesaroff, Director of the Eleanor Shaw Centre for the Study of Medicine, Society and Law at the Baker Medical Research Institute. He argues that if the unrestrained operation of market forces is introduced into the training of surgeons (together with the assumption that financial considerations are paramount in all clinical decisions) then economic values will penetrate the heart of the medical relationship. If economic values are made paramount in the provision of health services, patients will suffer where previously they have been assured of disinterested and compassionate care from their health care providers. Such circumstances would also create great costs and difficulties for the community.

10.47 In particular, the College contends that arguments made in favour of increasing the role of the market in the health care sector are flawed because:

- the assumptions underlying these arguments are based upon a flawed view of human action and relationships. The College highlights Komesaroff’s view that it is wrong to assume that:
  - consumers of medicine always act out of self-interest, use their own money to buy all goods and services and seek the best price quantity/quality combination; and
  - providers are primarily concerned with their own interests, adapt their prices and throughput in the light of consumers’ purchasing, act to maximise profits by increasing market share at acceptable prices and always seek to use labour and resources sparingly;

- the health care market contains distortions in pricing and in information. In particular, one of the primary reasons that the health care sector is different is that consumers are not in a position to make informed judgments about the services they need. The College contends that these judgements can only be made by trained professionals and are made independently of considerations of reward.

10.48 The College further argues the health care sector is clearly distinguishable from other sectors where pricing and advertising are often the primary consideration for purchasers because:

- most people do not acquire health care services on an ongoing basis, which reduces their ability to make appropriate choices;


44 Ibid.
• Medicare reduces the cost of the services of medical practitioners for consumers, with the consequence that they are likely to demand more of these services than if Medicare did not exist; and

• most people cannot understand the complex health care field, their needs are immediate and decisions about their health need to be taken at times of emotional pressure.

10.49 The College states that it has instilled in surgical trainees the ideals that are necessary to assist members of the community when at their most vulnerable to make choices regarding their health and lives. The College is concerned that a move from the current system would reduce its ability to ensure that patients’ interests are paramount;

• they fail to address concerns regarding the maintenance of standards; and

• they do not recognise and protect the non-quantifiable features of compassion and ethics that are inherent in the provision of medical services. The College contends that patients become dependent on doctors with whom they have established ongoing relationships of trust and who in turn are committed to their patients’ interest and that such a relationship cannot be understood purely as a commercial relationship.

Length of authorisation

10.50 The College contends that no time limit should be placed on the authorisation it seeks because the public benefits it has claimed in support of its application will be assured through the AMC accreditation process (see paragraph 1.24).
11. **SUBMISSIONS FROM INTERESTED PARTIES**

11.1 Upon receiving the College’s application and supporting submission, the Commission invited a range of interested parties to comment on them.

11.2 The Commission received over 80 substantive submissions from, among others, state and territory health departments, state and territory medical registration boards, specialist medical colleges, industry associations, consumer groups, private health insurance funds and university medical faculties.

11.3 An overview of all public submissions is provided below. Copies of all non-confidential submissions are available from the Commission’s Public Register.

**Government**

**Senator the Hon Kay Patterson, Minister for Health and Ageing**

11.4 Senator the Hon Kay Patterson reiterated her Department’s position in relation to the accreditation of surgical training posts. Namely, that there is currently no competent alternative body to undertake this task, as well as undertake the actual assessment of the surgical competency of overseas-trained surgeons. However, Senator Patterson indicated support in principle for the participation of other stakeholders in these processes, including the possible involvement of health departments.

**Specialist colleges generally**

11.5 In addition, the Commonwealth Department of Health and Aged Care submits that:

- ‘while acknowledging that there have been aspects of trainee selection and assessment procedures by a number of specialist medical colleges in the past that gave cause for concern (and some that are still being worked through), we have been pleased to note substantial progress in recent years by all specialist colleges in implementing recommendations of the Brennan report (in relation to trainee selection) and the Australian Medical Workforce Advisory Committee (in relation to numbers of specialist training positions). The Australian Medical Council and the Committee of Presidents of Medical Colleges have also been working together to develop improved processes for assessment of overseas-trained surgeons. Much of the progress made in workforce planning and policy has been at the instigation of the Department. We are, of course, well aware of areas of concern in the workforce and have been moving steadily towards rectifying these – with the cooperation of the specialist colleges, including the College’; and

- ‘it is essential that any desire to improve competitive/regulatory behaviours keeps to the forefront the critical objective of maintaining and improving public safety. The challenge is to ensure that the medical colleges implement selection and assessment processes which meet nationally agreed criteria in terms of timeliness, equity and transparency. All parties must be satisfied that any barriers to entry (beyond numbers which are determined independently of the Colleges) are based solely on standards, and do not reflect in any way the self-interest of professional groups seeking to control the market for financial or other gain for their
members’.

Competition law and medical workforce size

11.6 The Department submits that:

- ‘sensitive application of competition law is required in this extremely complex market, particularly when the College is only one of many organisations which influence the composition, availability and distribution of services in this market. We consider that any growth in the market should be tightly controlled, as there is no evidence of unnecessary growth leading to increased quality of health care’; and

- ‘a medical workforce in excess of population need does not necessarily reduce costs, does not necessarily improve access for under-serviced communities and is unlikely to improve health outcomes. Doctors are extremely expensive to train, and generate high incomes once in the workforce, both through Medicare and patient co-payments. It is the community (through taxation) which funds the major proportion of medical training, as doctors meet only a small amount of their training costs. A balanced medical workforce should therefore be the objective of governments, consumers and the profession’.

Surgical standards

11.7 The Department submits that:

- ‘Australian surgeons trained by the College have an excellent reputation internationally in terms of clinical competence and professionalism’; and

- ‘there is considerable public benefit in maintaining the confidence of the Australian public in the competency of surgeons who are authorised to practice in Australia, and in the Specialist Colleges who train and assess their qualifications and experience’.

Pro-bono work

11.8 The Department submits that the College’s ‘provision of pro-bono services… constitutes a significant public benefit’.

Selection, training and examination of surgical trainees

11.9 The Department submits that:

- ‘the College is the best placed organisation for the selection, education and training of surgical trainees in Australia’;

- ‘there is substantial public benefit in the well-documented College processes currently in place for the selection of trainees… We consider the College is the obvious and only organisation to perform this role’;

- ‘any perceived public detriment in the selection processes have been addressed or are currently being addressed. The Department is well aware of the situation in this regard, and has been working with the Medical Training Review Panel and all medical colleges in recent years to develop and implement nationally agreed
selection processes’; and

- ‘in the past policies advocated by the College have not always been fully implemented at state and regional levels by the Surgical Boards. However the College has been working actively towards developing a national or Australasian wide-ranking system in all specialty areas, and expects that appointment to such programs must be based on ranking and the number of available places’.

**Accreditation of hospital posts**

11.10 The Department submits that:

- ‘there is considerable public benefit in the well documented College processes currently in place for the accreditation of hospitals or advanced surgical hospital posts. We consider that in the interests of safety and quality of surgical training, it is necessary that the College is the organisation that accredits the training posts – we do not consider there is a alternative body with the competency to undertake this task’;

- ‘we do expect the College to adhere to nationally agreed processes to ensure that AMWAC recommendations for the number of training posts are met’;

- ‘while the Department agrees that high standards of quality must be maintained, we consider that the ongoing tensions between employing hospitals and the College regarding the accreditation of training positions must be addressed by all parties in the near future. Inevitably in discussions between state and territory funded hospitals and the College regarding the number of accredited advanced surgical training positions, each party will shift the responsibility for lack of positions to the other’; and

- ‘there should be clear delineation between the different processes for:
  - accreditation of hospitals and individual advanced surgical training positions by the College, and
  - the appointment of successful applicant Trainees to advanced training positions’.

**Overseas trained practitioners**

11.11 The Department submits that:

- ‘the processes in place presently offer significant public benefit by ensuring the competency of overseas trained specialists to practise in Australia, which outweighs any perceived detriment that the assessment processes may cause. The College assesses competency at the request of other agencies – although the College does appear to distance itself from the process in its submission, the fact remains that the College’s assessments do carry great weight in decisions made by other agencies to recognise the qualifications of specialists. We do not consider there is an alternative organisation to undertake the actual assessment of surgical competency. We do however believe that aspects of the assessment process may be streamlined to allow a quicker assessment by the College’;

- ‘assessment processes should be subject to external scrutiny by the AMC and
other bodies’; and

- ‘the current processes in place for assessing overseas trained specialists could be improved to make them more timely and transparent. However, the College is presently following well documented procedures for assessment of overseas trained specialists’.

**Funding**

11.12 The Department states that ‘we further feel it necessary that state and territory governments undertake to fund all advanced surgical training positions, once accredited, in line with AMWAC recommendations’.

**Appeals**

11.13 The Department submits that ‘it is essential that an impartial, transparent and equitable appeals process be maintained by all Specialist Colleges, and that the decisions of Appeals Committees are well documented.’

**General recommended principles**

11.14 The Department considers the following principles are necessary for the selection, assessment and training of the specialist workforce:

- adherence to nationally developed guidelines and processes, as agreed between peak bodies and state and territory and Commonwealth governments;

- that all processes for selection, assessment and accreditation of posts should be transparent, equitable, and timely;

- that appeals processes should be impartial, transparent and equitable and that decisions of Appeals Committees are well documented;

- that the roles of specialist medical colleges and state and territory funded hospitals regarding the accreditation of posts, and selection and appointment of trainees, should be clearly delineated;

- state and territory governments undertake to fund all advanced surgical training positions in line with AMWAC recommendations; and

- in the assessment of overseas-trained doctors, that a central (national) process be established for documenting numbers of applicants, decisions made and timeliness of responses.

**Minister for Health, the Hon Craig Knowles — New South Wales**

11.15 The New South Wales Health Department (NSW Health):

- supports granting authorisation subject to the concerns raised in its application;

- considers that ‘not authorising the arrangements would have a significant negative effect on surgical services in New South Wales’; and
• ‘does not support the establishment of an alternative training program for surgery as this would be inefficient given the relatively small market for surgical training’.

11.16 Generally, NSW Health submits that:

• ‘Australia has a world class system of training surgeons and implementing standards of excellence in the profession which is largely attributable to the work of the College… there is no need to make changes to the practices of the College at this level… the standards set by the College and its training role are not in question’;

• however, ‘the College’s practices with respect to the accreditation of training positions, the selection of trainees and the assessment of overseas trained specialists have the potential to the anti-competitive… [they] may limit the number of surgeons entering the workforce and therefore have the potential to reduce the effectiveness of the public health system’;

• ‘any anti-competitive effects may be offset by a public benefit argument on the grounds of maintaining surgical standards. However, the Department argues that there is a potential to increase the public benefit of the College’s arrangements through more open and transparent processes for selection of advanced trainees, accreditation of hospital posts and the assessment of overseas-trained specialists’.

11.17 NSW Health prepared its submission with input from the Area Health Services (AHS) who are the direct employers of medical staff, including surgical trainees working in the public hospital system.

Selection of trainees

11.18 NSW Health considers that the public benefit ‘can be enhanced by any measures which seek to increase the validity and transparency of the selection processes… increasing employer (AHS) involvement in the recruitment and selection process would be an appropriate measure in this respect’.

Accreditation of hospital training positions

11.19 NSW Health considers this benefit could be improved by increasing the validity and transparency of the arrangements for each of the surgical sub-speciality areas. For example, it suggests that increasing stakeholder involvement in the setting and reviewing of accreditation standards and processes would help ensure that the maximum number of funded positions are eligible for accreditation and that the accreditation criteria are valid and reasonable. NSW Health submits that trainee numbers are largely determined by the available number of accredited training positions and the number of applicants for these positions. It disagrees with the College’s claim that funding is the major determinant of numbers of surgeons in the public health system, citing that 53% of the total number of funded surgical registrar positions within NSW public hospitals are accredited by the College.

11.20 In NSW, the proportion of accredited training posts varies across the sub-specialties. For example, 47% of orthopaedic and general surgery training positions are accredited, while 85% of ENT training positions are accredited.

11.21 However, NSW Health notes that, with the exception of ENT surgery, the state is
currently meeting the surgical training targets set by AMWAC. It considers that if all surgical positions were filled with accredited trainees, then NSW would likely exceed those targets in some sub-speciality areas.

11.22 Furthermore, it considers the College needs to clearly justify its decisions in relation to the accreditation of some surgical positions and not others. This is especially important for non-accredited positions where the doctors filling these positions perform similar work, have the same working conditions, have access to the same hospital training facilities (the medical library, formal clinical meetings and surgical education meetings) and receive similar level of supervision as accredited trainees.

Assessment of overseas-trained doctors

11.23 NSW Health submits that the College’s arrangements for assessing overseas-trained specialists who wish to work in Australia are potentially anti-competitive because they limit the number of surgeons who potentially could work in Australia, especially in Area of Need positions.

11.24 NSW Health outlined that these arrangements drew significant criticism from a number of its AHS. In particular, while the College’s submission provides details of a fair and thorough assessment process for overseas-trained specialists, in reality the experience of some AHS is that the process is either not followed or inconsistently applied with examples of information booklets not being sent, interviews not being held, or multiple interviews occurring imposing considerable financial costs for applicants, particularly if applying from overseas.

11.25 In addition, NSW Health submits the assessment of overseas-trained practitioners is further obscured by the complex structure of the College and the relationship between it and its affiliated boards. NSW Health requests a clearer explanation of governance within the College, particularly the relationship between each sub-specialty and the College and the decision making powers of each in relation to the arrangements.

11.26 NSW Health submits that there are public benefits flowing from the processes by which overseas-trained specialists are assessed in the form of assuring that such surgeons meet minimum standards of safety and quality to work in Australia.

11.27 However, it considers that these processes could be improved by providing clearer information about the particular assessment criteria for each sub specialty so that prospective candidates understand how, and on what basis, they will be assessed by the College. Explicit criteria such as relevant benchmarks to be reached and detailed explanations of the components of training, experience and qualifications should be clearly stated and freely available.

11.28 In addition, the membership of the assessment panel could be broadened to include representation from the employer and an independent person, for example a community representative. Finally, NSW Health considers opening up the process will increase the confidence in the system for all stakeholders, that is overseas-trained doctors, employers and the community.

Minister for Health, the Hon John Thwaites– Victoria

11.29 The Victorian Government submits that while existing College processes may be soundly based, increased transparency regarding the criteria and selection processes
for decision making is desirable. Increased input from other key stakeholders would further assist the College achieving this.

11.30 In addition, the Victorian Government submits:

- ‘medical specialist training is heavily subsidised by state training and development grant funding (currently totalling approximately $36 million per annum) paid to public hospitals for trainee and clinical academic positions…and where such funding is provided, it is a contribution to salary costs (ranging from 75% of base salary for Hospital Medical Officers Year 6, when vocational training commences, to 54% of base salary for Registrars’;

- ‘while the accreditation of positions is considered to be the responsibility of medical colleges, the state would like to see transparency in the decision making processes’;

- ‘it is desirable to move towards a situation where the state actively determines the distribution of centrally subsidised…surgical training posts, whilst acknowledging hospitals will need to create additional training positions to support service needs where necessary’;

- it ‘…supports the proposal to broaden existing accreditation processes to provide opportunities for input from other key stakeholders;

- it supports ‘establishment of an appeals process …ensuring natural for potential trainees’; and

- it supports the AMC Accreditation Review recommendations with regard to the assessment of overseas trained surgeons including ‘that the RACS review its processes…to ensure that they are uniform between the sub-specialities and the time taken for review is minimised.’

11.31 The Department of Human Services, Victoria, supports granting authorisation. In particular, the Department also submits that:

- the Commission should ‘take into account the important of ensuring that there continues to be comprehensive models for surgical training in Victoria’;

- ‘the medical colleges (including the RACS) are the recognised training bodies and the arbiters of clinical and professional standards in Australia’;

- ‘there is widespread agreement that the standards of education and professional practice in Australia are high by international standards’;

- ‘the College is the most appropriate, independent assessment body for the selection of specialist surgical trainees and accreditation of surgical training posts;

- the Colleges’ role ‘satisfies Competition Policy public benefit principles on the basis of protecting public safety’;

- while recognising ‘that current mechanisms for determining the desired size and composition of the medical workforce can be improved… the College is not solely responsible for determining the number of entrants to specialist surgical
training…The AMWAC has been established as a national body with the express purpose of determining overall national trainee numbers. At a local level, hospitals and state and territory governments are also involved in determining trainee positions at specific hospital locations. The Department is satisfied that the College admits sufficient numbers to specialist surgical training to fill the positions so determined;

• it ‘seeks to provide the statewide public hospital system with funding for a number of accredited surgical trainee posts in observance of the recommendations of the AMWAC. To date, it has achieved AMWAC targets…’; and

• ‘the process by which the College accredits surgical trainee posts at specific hospital locations is not necessarily made clear to the Department and the hospitals concerned. It is important that this accreditation process is fully transparent to demonstrate that the College is objective in its workings and that the service requirements of the hospital are not unduly restricted’.

Minister for Health, the Hon Wendy Edmond – Queensland

Accreditation of hospital posts

11.32 The Queensland Minister for Health, the Hon Wendy Edmond submits that criticisms persist in relation to the College’s processes for recognition of overseas-trained surgeons and for accrediting hospital training posts. These criticisms include:

Accreditation of hospital training posts

• ‘training demands which result in unsafe hours of work as registrars strive to complete their log book of procedures and maintain contact with their surgical teachers’;

• ‘lack of transparency in the College process for the allocation of registrars’;

• ‘accreditation requirements unrelated to training, such as obligatory provision of office space to registrars’;

• ‘registrars (accredited training) and principle house officers (non-accredited) doing identical jobs’; and

• ‘denial of accreditation where total supervision is adequate but some of the supervisors are overseas-trained specialists’.

Overseas-trained surgeons

• ‘College rejection of applications for assessment of credentials by overseas-trained specialists on the basis that they are not permanent residents. This is a “catch 22” situation because they cannot be sponsored to become permanent residents until they have attained the Australian fellowship’;

• ‘College recommends a period of further training but available training places are restricted to Australian residents’;
• ‘there is a perception that age and personality influence decisions’;

• ‘overseas-trained specialists in supervised practice in an area of need prior to undertaking the Australian fellowship are prevented from attending training session available to local trainees, placing them at a disadvantage over local candidates’; and

• ‘pressure on hospitals to accept inadequate visiting sessional services rather than appoint an overseas-trained specialist’.

11.33 Provided its concerns are addressed (see below) – either by the College modifying its arrangements or the Commission imposing conditions of authorisation – Queensland Health supports authorisation of the arrangements.

11.34 It is concerned that ‘legal action by the ACCC may result in the collapse of the College and its training programs with disastrous results. It is unlikely that the programs conducted by the College could be readily reproduced by another body and, should another body assume the College role, the commercial cost of providing the programs would be prohibitive’.

11.35 Generally, Queensland Health submits that:

• the College is a ‘monopoly provider of surgical training in Australia, and… through this control, it is in a position to influence the number and quality of surgeons practising in Australia’;

• restricting the number of surgeons may result ‘in some cases in prices substantially above the Medicare Schedule Fees’. It also ‘compounds the maldistribution of specialist services, especially in geographically diverse states such as Queensland’.

• ‘the ability to maintain a higher price in private practice… results in difficulty with recruitment to the public hospital system’;

• it is ‘concerned that unrestricted access to surgical practice will increase training costs to the public system, could increase the number of procedures in situations where alternate forms of treatment are available and appropriate, and reduce the quality of services if surgeons are performing too few procedures to maintain competence’;

• the ‘high clinical standards set by RACS do result in the consumer… being able to have confidence in the quality and safety of surgical services’;

• ‘the RACS has a major role… in providing advice to assist policy makers with workforce planning. This advice is founded on the unique position of the College to understand surgical work practices and developments and to monitor the impact on the quality of services that may result from workforce planning decisions’;

• ‘there is an overwhelming public benefit that derives from the activities of the RACS in setting, developing and maintaining surgical standards… the great majority of those activities would not be of interest to the ACCC as they are unlikely to be anti-competitive… the RACS activities that have the greatest potential to limit access to the market include selection for the
college training programs, accreditation of training posts and the assessment of overseas specialist qualifications’; and

- ‘it is essential that the RACS continues to develop transparent, valid and reliable processes subject to effective appeals mechanisms and external accountability to government and the Australian Medical Council’.

**Accreditation of hospital posts**

11.36 Queensland Health submits that:

- it does not accept the College’s argument that it ‘has a peripheral role in determining how many funded training positions will be made available to trainees and where they may be located’;

- ‘funding is inextricably linked to the accreditation of training posts. There is no point, for example, providing funding for a training post if accreditation cannot be obtained. In many locations, funded unaccredited and accredited posts exist side by side, often carrying out identical service roles and participating in the same teaching activities’;

- ‘there is a very strong argument in favour of ensuring the quality of training in accredited positions’;

- it is ‘very important that the criteria against which a post is assessed are based on the best educational principles and good evidence for the link between requirements and training outcomes. The external scrutiny by independent outside bodies such as the Australian Medical Council and accountability to government are essential. As an example, in sub-specialties with small numbers of specialists in one geographical location, College requirements for supervisor numbers must be reasonable and clearly linked to demonstrated outcomes’;

- ‘there should be movement within the College towards consistency of requirements for supervision between its specialty areas’;

- ‘the objectivity and external scrutiny of the [accreditation] process could be enhanced by the inclusion on the team of a member who has no connection with either the hospital (and health department) or the College’;

**Minister for Health, the Hon Bob Kucera – Western Australia**

11.37 The Western Australian government submits that:

- ‘the availability of adequate numbers of specialist surgeons across the spectrum of required surgical specialties is a matter of core interest to the Government of Western Australia’;

- ‘Western Australia is experiencing increasing reliance on overseas trained doctors to staff the WA public hospital system. Furthermore, it seems evident that medical specialist shortages [are] contributing to a long term ramping up of the unit costs of medical services in the public hospital system’;

- ‘public hospital specialist surgical services, particularly emergency surgical
services, are an essential public service. Because of this, government has a responsibility to ensure that these services are available when required... this is not a responsibility that government can leave to an independent non-government body without adequate safeguards;

• it is ‘concerned about the apparent limitations in the accountability arrangements and transparency in the way RACS performs their essential function of training and maintaining an adequate medical specialist workforce’;

• ‘the present arrangements do not provide sufficient information for government to determine the extent to which RACS policies and processes... are factors contributing to shortages of surgeons...’

• it has ‘not seen convincing evidence that justifies a hands off approach to the oversight and regulation of the processes required to ensure the supply of sufficient numbers of specialist surgeons...’

• ‘the RACS has a responsibility to inform the community and government of the detail of its training policies and practices, including the processes for accreditation of training posts and the standards in regard to the specific skills and competencies required by candidates seeking RACS accreditation’;

• ‘RACS policies and processes in respect to the selection of candidates... [and] the actual training of specialist surgeons should be available to outside scrutiny and if necessary audit’;

• having said all this, ‘it can be difficult to discern the specific reasons for specialist medical practitioner shortages because of the interplay of a variety of other factors apart from the possible influence of ... the RACS’;

• ‘notwithstanding the medical workforce reviews undertaken by the AMWAC, there continues to be considerable uncertainties in the determination of the required number of medical specialist training posts and the way these posts are filled from year to year’;

• ‘there is good evidence that medical specialists... operate in a national market... a failure of supply in one part of the country... is likely to affect the supply of specialists in other parts of the country... the potential for such a situation to arise is justification in itself for national regulatory supervision of internal national factors that could unnaturally limit the supply of specialist surgeons’;

• ‘the location of medical specialist training is an important factor in influencing the long term geographic distribution of medical specialist services... it is important therefore that there are not artificial barriers limiting the geographical spread of surgeon training posts’;

• ‘because of the time taken to complete specialist training, when supply problems emerge it will normally take several years to overcome supply deficits. Over this period, the existing specialist medical workforce will be substantially insulated from normal competitive market pressures’;

• ‘there is significant potential for supplier leverage in the overall marketplace for
specialist medical services even where the supply shortfall is confined to a particular specialty’;

• ‘given the existence of sub-specialisation and the often relatively small numbers of specialists concerned, there is the potential at least to artificially create shortages in either the public or private sectors’;

• ‘it has been reported that there has been a noticeable increase in the average age of medical specialists in certain specialties. If this is not recognised early by the relevant medical specialist colleges it can be a cause of future shortages’;

• ‘advances in technology and in the skill levels and competencies of related categories of health workers may have the potential to reduce the rate of growth in the need for particular categories of medical specialist. The RACS specialist training processes should not be allowed to inhibit such trends where there are no additional risks to patient safety and treatment outcomes’.

Minister for Health, the Hon Lea Stevens – South Australia

11.38 The South Australian Government submits that the College is not ‘ready to be granted the authorisation as requested’ due to the fact that the College ‘has not yet recognised the need to consult and engage the employer responsible for the funding and provision of public health services, and in particular, to assist it in addressing areas of need’. In particular the South Australian government submits:

• ‘there are significant difficulties in obtaining recognition of overseas-trained…surgeons…in terms of assessment and the completion of the requirements for registration to practice as surgeons in the areas of need’;

• ‘in 2002 the College accredited 10 basic surgical training posts in South Australian teaching hospitals, compared with 20 in previous years…The Department was alerted to this problem by the Directors of Training in the teaching hospitals who will confirm that the change did impact on the staffing of South Australian public hospitals’;

• ‘…of 185 approved positions for training, only 10 were allocated to South Australian residents. It is believed that there were…serious inconsistencies in the assessment of candidates between the various states and that these…worked against South Australia’;

• ‘it also appears that the number of positions was determined amongst other factors on the training capacity of each state and the RACS significantly under-estimated the training capacity in South Australia’;

• in relation to the College’s claim that training of surgeons is, in large, a voluntary activity undertaken by College Fellows, … ‘Visiting Medical Officers’ Awards and the full time and part time South Australian Medical Officers’ Award…have a requirement for teaching and training of both undergraduate and postgraduate medical students’; and

• ‘the rate of remuneration includes a component of teaching of post graduate students and the allocation of duties by hospitals includes this requirement’.
Minister for Health, Jon Stanhope – Australian Capital Territory

11.39 The ACT Government submits that the College, through its processes for assessing the suitability of prospective surgical training posts, has a direct influence on the number of training posts and the number of new surgeons entering the profession. While the government accepts that it is in the public interest for the College to set standards and have formal accreditation criteria for training posts, the arrangements, to date, have been unsatisfactory in meeting the needs of the public health sector in the ACT in terms of the number of surgeons.

11.40 The ACT Government supports authorisation, subject to the following concerns being addressed:

- there is a need for a process that links the number and distribution of accredited training positions with workforce planning processes in individual states and territories;
- the criteria for accrediting training posts need to be explicit and open to external scrutiny; and
- decisions made by the College should be subject to appeal. Clear processes for lodging appeals and their assessment would need to be established.

11.41 The Commission also met with the Department of Health following its request for additional information in August 2001.

Identifying new training positions

11.42 The Department explained that the responsibility for identifying new training posts in the ACT rests with clinical departments within individual hospitals. The Department does not provide the funding specifically for such posts, rather, they are funded from the budgets of the relevant clinical department.

11.43 In relation to obtaining accreditation from the College for new training positions, the Department submits that the College has complete control over this process, which involves assessing the proposed post against accreditation criteria such as the volume of work and academic infrastructure at the hospital.

Nonaccredited training positions

11.44 The Department considers there are two factors which determine the number of registrars in hospitals. These are the number of accredited training positions and the service requirements of the hospital. In this regard, nonaccredited training positions exist to meet hospital servicing requirements. It submits that in the ACT the number of training posts required to service a hospital is higher than the number of accredited training posts required for medical requirements.

11.45 Furthermore, the Department considers the number of nonaccredited training posts is likely to increase in the future, as an increasing number of junior doctors is being required to meet service requirements. As at July 2001, there were 5 nonaccredited surgical training positions in the ACT. At the same time, there were 15 accredited surgical training positions in the ACT.
11.46 The Department considers that generally there is no difference between nonaccredited and accredited training posts. In some cases, differences between such posts may include:

- the individual occupying the post is unable to hold an accredited post (for example, an overseas-trained practitioner without the appropriate visa);
- the post failed to meet the College’s accreditation criteria; and
- the amount of time spent with a supervisor/mentor would be higher in an accredited post.

**Provision of surgical training**

11.47 In relation to the provision of surgical training, the Department considers surgeons provide training on a partial pro bono basis. VMO contracts explicitly require surgeons to provide training. However, no particular payment is linked to this requirement.

11.48 In addition, the Department submits that it is implicit in accepting a VMO appointment that surgeons provide surgical training. However, it suggests that it would be difficult to enforce this requirement.

**Department of Human Services – Tasmania**

11.49 The Department of Health and Human Services provided background information to the Commission in response to the Commission’s request for additional information in August 2001. It noted that its earlier decision not to provide a submission ‘did not imply criticism or dissatisfaction with the RACS…’.

11.50 The Department outlined that AMWAC recommendations are accorded a high priority in establishing a new training post. Within Tasmania there are three hospitals which are engaged in specialist training in various disciplines, and which are primarily responsible for identifying potential new training posts. These hospitals are the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital. The decision to identify a new training post is a joint decision between the individual hospitals and the Department. Need and cost considerations are important factors in reaching this decision. Cost considerations include the salary and on-costs of training posts and related infrastructure costs. An AMWAC recommendation for a new training post would have a very strong influence on the relative merits of the proposed post against other possible training and service posts.

11.51 The Department submits that there has been considerable discussion in various national groups concerning ‘accredited’ and ‘non-accredited’ training positions, particularly in surgery and sub-surgery specialties. The term ‘accredited’ training position has been used to identify a position which is recognised by the relevant College as providing an appropriate level of experience and supervision. The term ‘non-accredited training post’ has been used to identify a position which is not recognised by the relevant College as providing an appropriate level of supervision and experience.

11.52 The Department submits that non-accredited training positions, of which there are few in Tasmania, exist to meet a hospital’s servicing requirements. A doctor may work in
those positions to gain experience while waiting for an accredited training position to become available. It submits the number of non-accredited training positions in Tasmania is unlikely to increase.

11.53 In respect to the provision of training by surgeons, the Department submits that some of the training is undertaken in paid time. For example, when performing surgical procedures and during ward rounds and outpatient clinical attendances the surgeon would be providing training to junior medical staff in the course of patient treatment. Other training activities such as lectures and workshops would sometimes be conducted in paid time, although more frequently those activities would be undertaken in unpaid time.

11.54 In addition, VMO contracts for surgeons contain a clause that the surgeon ‘may be required to provide teaching and/or research’ as a component of the contract. Surgeons are paid for teaching activities provided in accordance with such a requirement in their VMO contract.

The Australian Medical Council

11.55 The Australian Medical Council (AMC) mainly focuses on the issue of overseas-trained specialists. A large part of the AMC’s submission is summarised in the background section of this draft decision.

11.56 The AMC submits that:

• ‘prior to 1990, overseas-trained specialists… were required under legislation in force to obtain general (non-specialist) recognition… the screening examination required the overseas trained doctor to be assessed across a wide range of topics and conditions… for the majority of overseas-trained specialists, many of whom had been working in narrow fields of specialist practice, the need to pass a screening examination in general medicine represented a major obstacle…’;

• ‘the current process is far more appropriate and equitable’;

• ‘there are significant variations in the training and professional experience of specialists [between countries]. In some cases, specialist training … follow the pattern … in countries such as Australia, the United Kingdom and Canada. In other countries, such as those in Eastern Europe, specialists may commence their advanced training during the last years of their basic medical course. The effect of these variations is that a large number of overseas-trained specialists will not be able to establish full equivalence with Australian trained specialists without additional training to cover aspects of specialist practice that were not part of their original specialist training or experience’;

• ‘if authorisation… is withheld, and the College (and possibly other specialist colleges) withdraw from the assessment process, it would represent a significant retrograde step. Such an outcome would remove an important avenue by which overseas-trained specialists can establish their eligibility for registration. The only alternative for many of these specialists would then be to attempt the AMC examination for general registration. In the absence of suitable re-training and bridging courses in Australia, this would represent a considerable hardship for
many overseas trained specialists…’; and

- ‘any lessening of standards of overseas-trained specialists could have serious consequences for health outcomes’.

11.57 On another matter, the AMC points to the College’s supporting submission which states ‘the College plays no role in determining the quotas set for the admission of overseas-trained practitioners to practice in Australasia.’ The AMC outlines that this statement is not correct. In fact, there is no quota on the numbers of overseas-trained doctors that can enter the medical workforce in Australia. In the past there was a quota of 200 places per year on the AMC clinical examination in an effort to regulate the numbers of doctors entering the workforce. However, no quota was set on the number of overseas-trained doctors who could apply for assessment from specialist colleges. In August 1995, the quota on the AMC examination was removed and currently there is no set limit on the number of overseas-trained doctors who can sit the AMC examination.

State medical boards

The Medical Board of South Australia

11.58 The Medical Board of South Australia has the statutory responsibility for medical standards within South Australia. The Board strongly supports the application for authorisation.

11.59 The Board also notes the ‘extreme difficulty in assessing the qualifications of overseas-trained surgeons whose training has taken place in institutions of variable quality and standards’. The Board is of the opinion that the standard of such surgeons is ‘best judged by the established system integrating the College and the AMC’.

The Medical Board of Queensland

11.60 The Medical Board of Queensland submits that:

- it ‘relies heavily upon the College’s assessments in reaching its determinations on applications for specialist registration from overseas-trained doctors, both as long term registrants with full recognition or for a shorter duration for specific purpose’;

- should the College’s application be denied, the College ‘and presumably other specialist colleges will no longer be in a position to provide such assessments’;

- the Board ‘does not possess the expertise or the resources to evaluate the training of overseas specialists... the loss of the capacity to assess the training of overseas specialists would have devastating consequences on the Board’s ability to assure that safe and competent specialist practice is available in the state of Queensland, and would certainly reduce the availability of overseas-trained specialists for filling vacancies in this state’.

Medical Board of Western Australia

11.61 The Medical Board of Western Australia submits that the arrangements for which authorisation is sought ‘appear to be well thought through and provide a transparent
mechanism in the selecting and training of surgeons in Australasia’.

Specialist medical colleges

Committee of Presidents of Medical Colleges

11.62 The Committee of Presidents of Medical Colleges (the CPMC) strongly supports the application for authorisation and endorses the College’s submission. It emphasises that the College’s training program ‘confers an extraordinary financial and quality benefit [on] the public’.

11.63 The CPMC also submits that:

- ‘surgeons must be trained by surgeons’;
- ‘specialist medical colleges play a peripheral role in setting the number of specialists produced in Australia’ and that this number is, in fact, determined by government, through the AMWAC process. The specialist medical colleges have ‘co-operated with the AMWAC process and complied with recommendations’;
- ‘state and territory Governments, not colleges, fund the training places which, in a substantial number of areas, fall short of the number required to meet AHMAC/AMWAC recommendations… [also] in some surgical disciplines, insufficient medical graduates are attracted to …fill available funded posts’; and
- those bodies which refer overseas-trained practitioners to the College ‘for assessment of equivalence can, and do, reach their own conclusions concerning employment decisions and conditions and registration conditions’.

The Royal Australasian College of Physicians

11.64 The Royal Australasian College of Physicians (RACP) supports the application for authorisation and, subject to the Commission being satisfied with the AMC accreditation process, considers that authorisation should not be time limited.

Accreditation of hospital posts

11.65 The RACP submits that:

- if colleges are to ensure quality of training… they must be able to determine the suitability of hospital training positions taking into account the resources available to support those positions’; and
- the College can only ‘select and train as many trainees as there are funded and accredited positions in hospitals. This means that the RACS, as with other colleges, has a very limited role in influencing the number of practitioners in training. The availability of training positions is primarily determined by the federal, state and territory governments and the hospitals which rely on them for funding’.

Selection of trainees

11.66 The Brennan report ‘recommended a best practice framework for selection of trainees
into specialist medical training programs. The RACP understands that the College is conforming to that framework’.

Assessment of overseas-trained practitioners

11.67 The RACP submits that:

• ‘the RACS and other specialist colleges are asked by government agencies to assess the qualifications, training and experience of overseas trained medical practitioners… while in most cases, the relevant agency accepts the advice of the colleges (and there have been numerous exceptions), the colleges are acting only in an advisory capacity’;

• ‘RACS has set out the detailed process it follows to determine whether overseas-trained specialists have training and experience equivalent to the high standard of those who pass through its own training programs. To argue that a lower standard should apply to overseas-trained specialists would be untenable…’.

Public benefits

11.68 The RACP:

• ‘wishes to emphasise the importance of colleges establishing and maintaining high standards of specialist medical care for the Australian community’;

• ‘the services provided by the specialist medical colleges are provided on a pro bono basis… the training of specialists within the hospital and community health system is at no cost to the community other than through government funding of hospital positions for health service delivery as well as for training’;

• ‘the pro bono work of the fellows of colleges is enormous. It includes involvement in selection processes, supervision of trainees, the conduct of examinations and other forms of assessment, training of supervisors, counselling and mentoring trainees and the development and delivery of didactic training systems’; and

• ‘this model of training is … extremely cost efficient. The costs associated with establishing a new entity to take on this role would be very substantial’.

11.69 The Australasian Faculty of Public Health Medicine, within the RACP, also urges the Commission to give serious consideration to arguments made by the College (see paragraphs 10.45-10.49) about the adverse impact of ‘making economic matters paramount in the doctor-patient relationship’.

The Royal Australian and New Zealand College of Ophthalmologists

11.70 The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) strongly supports the application for authorisation.

11.71 Specifically, RANZCO submits that:

• the number of surgical trainees is limited only by the availability of hospital training posts, which must be funded by government;
• the accreditation of hospital training posts is ‘essentially a standards issue based on guidelines, and is not directly relevant to the availability of posts’;

• ‘the process of assessing overseas-trained doctors is also a standards issue and the College’s role is advisory and in the public interest’; and

• ‘even if… some aspect of the process or system used by Surgeons could be deemed to be anti-competitive, that any detriment would be far outweighed by the benefits.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

11.72 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) strongly supports the College’s application for authorisation.

11.73 RANZCOG submits that the College’s training program, selection procedures and its procedures for the assessment of overseas-trained specialists are open and transparent.

11.74 It further submits that the availability of training positions is determined by state governments who fund staffing levels at public hospitals, and that colleges utilise all hospital positions which provide adequate training situations for their training programs. It submits that the College is unable to restrict the number of training positions.

Australian and New Zealand College of Anaesthetists

11.75 The Australian and New Zealand College of Anaesthetists (ANZCA) submits the arrangements for which authorisation is sought benefit the public, and that these arrangements outweigh any perceived anti-competitive detriment.

11.76 The ANZCA notes that government funding is a ‘limiting factor in the number who can be trained’, including because it is a limit on the number of surgeons that can be employed to conduct training.

Australasian College for Emergency Medicine

11.77 The Australasian College for Emergency Medicine (ACEM) supports the College’s application. In particular, it considers that:

• ‘training provided by the College is largely honorary and if fully funded would result in immense additional cost to the health system, and ultimately to consumers’;

• it is uncertain whether a commercial training body ‘would be able to achieve the same level of co-operation and dedication’ from surgeons, even if they were to pay market rates;

• the College ‘is not in a position to restrict training programs’. State governments are responsible for funding training positions. Availability of trainees for training positions is determined by the number of university graduates and competition from other training programs;

• ‘increasing community interest in medical standards and adverse events in the
health sector mandates a rigorous approach to surgical standards and training’;

• ‘registration authorities have full power to accept or reject the recommendations of both the AMC and the College’; and

• ‘there is no alternative for the provision of surgical training in Australia that could deliver equal quality outcomes for a lower price to the consumer’.

The Australian College of Dermatologists

11.78 The Australian College of Dermatologists (ACD) supports authorisation of the arrangements and the College’s submission.

11.79 The ACD also makes the following points:

• ‘the numbers of trainees and their employment are largely the responsibility of the state government through their public hospital system’;

• the College’s role in assessing overseas-trained surgeons is an advisory one only, and it is not responsible for further action regarding their registration or ability to practice;

• accreditation of hospital training positions is necessary to maintain the high standards of surgical training in Australia;

• training is provided at ‘minimal cost’ because of the ‘enormous amount of voluntary unpaid time and effort provided by Fellows’ of the College.

The Royal Australian and New Zealand College of Psychiatrists

11.80 The Royal Australian and New Zealand College of Psychiatrists supports the application for authorisation. It considers it is in the public interest that post graduate medical training remains strictly with specialist medical colleges.

The Royal Australian and New Zealand College of Radiologists

11.81 The Royal Australian and New Zealand College of Radiologists (RANZCR) generally considers ‘that there is significant public benefit deriving from the training and assessment functions of medical colleges in Australia… which, by far, outweigh[s] any anti-competitive detriment which may be found to exist in individual circumstances’. The benefits to the public include:

• ensuring the provision of high quality medical services to the Australian community;

• the provision of high standards of medical training in Australia and overseas;

• the major voluntary contribution to that quality training made by experienced College Fellows;

• the objective, professional assessment of the training, experience and skills of both Australian-trained and overseas-trained specialists, undertaken by medical colleges in the interests of ensuring the maintenance of minimum acceptable
standards of practice in Australia; and

• the significant financial savings achieved by the current arrangements. Any alternative system of training and or assessment of medical specialists would be likely to be prohibitively expensive.

11.82 In addition, RANZCR submits that:

• Australian medical colleges ‘play essentially no role in determining the number of training positions in any medical speciality’;

• the ‘availability of training positions is directly dependent upon the willingness of governments to fund training positions’;

• ‘the College’s quite recent experience has been that even AMWAC recommendations… in regard to the need for additional training positions to meet the relatively short-term requirements of the Australian community are not sufficient to influence the relevant government(s) to fund the positions proposed’; and

• ‘there is no viable alternative to the present arrangements. The cost to the community of introducing an alternative form of commercial training arrangement is likely to be beyond the community’s ability to pay. More important than the cost consideration is the issue of skill and expertise which has been developed within and resides essentially within the medical colleges’.

The Royal College of Pathologists of Australia

11.83 The Royal College of Pathologists of Australia (RCPA) supports the application for authorisation.

11.84 In relation to the College’s training program, the RCPA submits that:

• ‘it is the state and territory governments that determine the number of funded trainee positions… and where those positions will be located. Typically, hospitals will receive an amount of funding from the government and will decide how this funding is to be allocated to medical staff appointments, including training positions for trainee medical specialists’; and

• ‘the most ideal training method for medical specialists is one based predominantly on the ‘apprenticeship’ model of education… where there are significant disparities between the capacity to train and the number of trainee medical specialists, there is a real risk that the trainee medical specialist will not progress professionally in the relevant examinations. Additional training and re-training is at a cost to the system…’

11.85 The RCPA submits the purpose of the College’s accreditation program is ‘to ensure that only hospitals which have sufficient resource to provide the appropriate level of training, without significantly impacting on the day to day operations of the hospital, are accredited’.

11.86 In relation to the assessment of overseas-trained practitioners, the RCPA submits:
• the College does not determine the number of overseas-trained practitioners who can practice in Australia. Rather, it assesses the qualifications of overseas-trained practitioners on behalf of the AMC and state and territory medical boards in an advisory capacity. ‘It is for government bodies and employing agencies to make the final determination’; and

• there is substantial benefit to the public by ensuring that specialists working in Australia (both those trained here and overseas) have the knowledge and skills required to provide high quality and safe medical care. Conversely, a poor standard of medicine not only leads to higher levels of adverse medical outcomes, including death and disability, but also leads to additional costs of services provided for no useful or beneficial effect.

11.87 The RCPA also submits that there are significant cost savings to the community through the voluntary work and training programs provided by the Fellows of the College.

11.88 The RCPA further submits that, if alternative training organisations were to be established to the College, ‘it is questionable [whether surgeons] would continue to undertake [training] activities on a voluntary basis, especially in the current professional environment of cost cutting and increasing personal workload’.

The Royal Australian College of General Practitioners

11.89 The Royal Australian College of General Practitioners (RACGP) supports the application for authorisation ‘to the extent that the application seeks to maintain standard setting and related matters for surgery in the hands of the College’.

11.90 Among other things, the RACGP submits that:

• ‘the selection criteria for trainees, vocational training, professional standards, accreditation of teaching environments and standards for maintenance of professional competence should be in the hands of the professional bodies that were constituted for the purpose and are uniquely qualified to do so’;

• many aspects of surgical training require close and careful expert supervision through an apprenticeship model of learning. This mechanism… has served communities well throughout the world… indeed, it is through this mechanism that the discipline of surgery and other medical disciplines have been transformed from their rather humble beginnings to the high standard of success that is reliably offered to the community today’; and

• it can ‘speak with authority on alternatives. Despite clear evidence of a successful internationally recognised program for general practice being provided by the RACGP… government has imposed an alternative competitive model of training on ideological grounds. This has caused overwhelming confusion in the community and has led to great stress among existing and prospective trainees. There is no evidence whatsoever that the proposed new model will be successful. In addition, it has brought with it a significant increase in bureaucracy and all indications are that general practice training is going to cost the community more in the future’.
Medical Societies/Associations

Australian Healthcare Association

11.91 The AHA is the national industry association for the public hospital and healthcare sector. Its members are the hospitals that provide places for specialist medical training. The Australian Healthcare Association (AHA) supports the continuation of the College’s current role as detailed in the application for authorisation.

11.92 The AHA submits that the benefits from the Colleges role in training surgeons are considerable and include:

- ‘significant inputs of time and expertise by a learned body at no or minimal cost to the public purse’;
- ‘committing to a lifelong culture of learning among a large number of practising surgeons through their involvement in the training process’; and
- ‘continuous process of quality improvement, renewal of the knowledge base of practising surgeons and regular, critical evaluation of their practices’.

11.93 In this regard, AHA considers these benefits could also be realised through alternative training models. However, should changes be made to current training processes, if these benefits were no longer available to the hospital system, they would be difficult and costly to replicate.

Post graduate medical training

11.94 The AHA submits that there may be some advantage in shifting the responsibility for post-graduate medical training from the medical colleges to the tertiary education sector. This was recently introduced for GP post graduate training, where an additional body was established so that the RACGP no longer has a monopoly role as the provider of GP post graduate medical training.

11.95 However, the AHA submits that introducing a similar model for the training of surgeons would be a significant logistical and expensive exercise.

Recommendations for improvement

11.96 The AHA notes the perception that the College has a ‘closed shop’ approach to limiting graduates through its monopoly power of trainee selection, accrediting of hospital training posts and assessment of the qualifications of overseas-trained surgeons. To address these concerns, the AHA recommends the College maintaining a more systematic information base and processes that may detect problem areas. This would include:

- ‘measures of gender balance and trainee selection’;
- ‘independent (non-RACS) appeal mechanisms relating to trainee selection, post accreditation and assessments’;
- ‘adoption of recommendations relating to geographical distribution of places and
part-time or flexible training posts’;

- ‘broader publication of the performance of the College in meeting AMWAC recommendations’; and

- ‘systematic evaluation of the quality of individual surgeons in their capacity as teachers and trainers’.

Australian Medical Association

11.97 The Australian Medical Association (AMA) strongly supports the application for authorisation. It believes there are significant public benefits arising from the arrangements including public health and safety and savings to the public purse from:

- the provision of pro-bono training;

- not training potentially excessive numbers of surgeons; and

- avoidance of costs associated with supplier induced demand.

Health and safety

11.98 The AMA submits that:

- ‘surgical services are qualitatively different from other services provided in the community… quite literally, [they] involve questions of life and death. The public demands the very highest standards of knowledge, skill and expertise from surgeons… there is a very high public expectation that entry into the surgical profession is limited to a very small number of individuals’ who meet these standards;

- ‘there is an inverse relationship between the number of people in the pool that may be able to provide surgical services and the level of knowledge, skill and expertise of those in the pool… as the pool becomes larger, the greater will be the variation in the level of competence of those surgeons in the pool;’

- this greater variation ‘will cause difficulties for uninformed consumers in being able to distinguish between more or less competent providers’. In support of this contention, the AMA notes that ‘the purchases of surgical services are generally made infrequently by consumers and often at a time when, through illness and emotional strain, their decision-making abilities are reduced. Additionally, a disproportionate number of surgical services are consumed by those from lower socio-economic and educational attainment backgrounds. This means that consumers are unlikely to be able to make sophisticated judgements in selecting a [surgeon].’

Pro-bono training services

11.99 The AMA supports the College’s claim that it trains surgeons on a pro-bono basis, amounting to savings of several hundreds of millions of dollars to the public. In addition, it believes if authorisation is not granted, ‘with increasing numbers of surgical providers entering the market for the supply of surgical services… many existing surgeons would be unlikely to train their future “competitors” on a pro-bono
basis… significant additional public expenditure would be incurred in order to pay market fees for surgical trainers and supervisors… this would be at least three times the total level of any possible savings resulting from a reduction in surgical fees’.

Not training potentially excessive numbers of surgeons

11.100 The AMA submits that:

- ‘there is a considerable public benefit in trying to determine an optimal number of surgical providers given the likely demand for those services’ particularly given College figures that it costs at least $100 000 per year per trainee to train a surgeon; and
- that the Commonwealth and state governments recognise this benefit by establishing AMWAC.

11.101 The AMA further submits that:

- if the ‘application is not approved, there is a potential for an oversupply of surgical providers to develop and for the services of some surgeons to be under utilised - with resulting degrading of surgical expertise and skill and waste of training subsidy’;
- ‘if an increased throughput of trainees results from the failure of this application, there is likely to be a diminution in the range and depth of experience gained by trainees prior to gaining Fellowship – with a consequent reduction in standards… the costs of which would more that offset any reduction is surgical fees in Australia’;
- ‘the increasing level of specialisation of surgeons means that an increased population base per surgeon is required in order to maintain the viability of practice in a particular sub-specialty. If the number of suppliers is increased, the practice of particular sub-specialities may no longer be viable… this would particularly impact on rural Australia’.

Avoidance of costs associated with supplier induced demand

11.102 The AMA submits that ‘a feature of the markets for medical services is the capacity for suppliers in some situations to induce additional demand for their services. In the surgical context, in a market where there is an increased number of surgical suppliers, this could result in a greater propensity to undertake surgical interventions given a range of possible treatment options. To the extent that additional surgical interventions are unnecessary or a less optimal treatment option, this would result in additional public expenditure’.

Influence of government on surgical numbers

11.103 The AMA considers that surgical numbers are ‘more influenced by the willingness of state and federal governments to funding training positions… or decisions of the Australian Medical Council to recognise an overseas qualification… than by the actions of the College’.
Relative Value Study (RVS)

11.104 The RVS is a joint government/AMA examination of medical fees in Australia undertaken over six years. The AMA submits that it shows that ‘surgical fees have moved in line with reasonable economic indices over many years’.

Time limit

11.105 The AMA submits that ‘given the limited impact that [the College’s] proposal may have on the supply of surgeons… the ACCC should not impose any time limit on the authorisation.

11.106 The Queensland branch of the Australian Medical Association (AMAO) supports the application for authorisation. Among other things, it submits that ‘number of trainees is a factor controlled by the state health department, but in which there are four other vital factors. These are:

- funding;
- a minimum patient base;
- an appropriately qualified supervisor/trainer/mentor; and
- access to appropriate facilities’.

11.107 AMAO submits that it is arguable whether competition improves health care standards. In addition, ‘inconsistency across surgical approaches and individual surgeons caused by different methods of selection, training and assessment’ would not benefit the public.

11.108 AMAO submits there is benefit to the public in that the majority of the College’s work is provided at no cost to the government.

The Australian Society of Otolaryngology - Head and Neck Surgery

11.109 The Australian Society of Otolaryngology - Head and Neck Surgery (ASOHNS) supports authorisation of the arrangements. It submits that the present system will collapse if authorisation is not granted.

The Urological Society of Australasia

11.110 The Urological Society of Australasia supports the application for authorisation, and submits that ‘the public benefit in terms of maintaining the highest standards of urological practice is manifest’.

11.111 It also submits that surgeons provide training without any financial remuneration, which generates a ‘huge saving in expenditure’.

11.112 The Society notes that assessing overseas-trained practitioners ‘can be a difficult process as it can be time-consuming and difficult to verify the competence of [these] urologists, particularly without any period of vocational assessment’.

Australian Orthopaedic Association
11.113 The Australian Orthopaedic Association (AOA) ‘fully supports’ the College’s application.

11.114 In particular, the AOA submits that:

- ‘the availability of training posts and trainees to fill medical specialist training posts is not limited by the College but determined by many factors including the number of medical graduates, their preferences for further specialist training, and by hospital funding and government budget decisions’;

- the College’s Board of Orthopaedic Surgery is advised by the AOA’s Training and Membership Committee and membership of these committees is not the same. The Board of Orthopaedic Surgery reports both to the College and the AOA so as to ensure communication between the College and orthopaedic surgeons; and

- the Board of Orthopaedic Surgery ‘has helped in the process of assessment of overseas-trained orthopaedic surgeons by providing extra positions for them on training programs (lateral entry)’.

The Australian and New Zealand Society for Vascular Surgery

11.115 The Australian and New Zealand Society for Vascular Surgery (ANZSVS) strongly supports the application for authorisation.

11.116 The ANZSVS submits that the number of trainees is ‘largely determined by external factors, including the number of graduates from the universities, their preferences for further professional development and, critically, government and hospital funding decisions’.

11.117 ANZSVS also submits that the costs of poorly performed vascular surgery are very high - for example, amputation if a bypass graft fails.

11.118 The President of the ANZSVS, who signed off the submission, is also a Councillor of the College and Head of the Department of Surgery at the University of Sydney. In this latter role, he indicated that the University of Sydney is ‘not in a position to undertake the role of the College, nor does it have the resources for this particular task. There has, however, been increasing collaboration between the universities and the College, notably with the implementation of basic surgical training programs and in proposals to base surgical skills centres in the university settings’.

The Australian Society of Plastic Surgeons

11.119 The Australian Society of Plastic Surgeons (ASPS) is an independent organisation which represents the majority of surgeons trained in the specialty in Australia. Its Articles of Association ‘extend to establishing and maintaining appropriate programs of training in our specialty. This service is provided under the co-ordinating umbrella of the College, with whom a close affiliation exists through the [College’s] Board of Plastic and Reconstructive Surgery (BPRS). This latter structure is independent of the ASPS and is solely concerned with training and standards’.

11.120 The ASPS fully supports the application for authorisation. Among other things, it submits that:
• the ASPS and the College have ‘no influence as to the availability of training posts and of doctors who apply to fill them. This is very much determined by many factors, not the least is government and hospital health policies and budgets… the BPRS fills all funded positions unless there is a shortfall in appropriately qualified trainees’; and

• the arrangements for which authorisation is sought ‘are provided free of charge, which generates an enormous cost saving to the community and the government’.

Health funds and private hospital groups

Mayne Nickless

11.121 Mayne is particularly concerned about the restrictions relating to:

• the assessment of overseas-trained surgeons; and

• the accreditation of hospital training positions.

11.122 It submits that ‘these restrictions have artificially reduced the number of surgeons available to operate in Mayne’s hospitals throughout Australia, particularly in rural and regional Australia’.

11.123 Generally, Mayne submits that it ‘is not seeking to change the standards which must be met by specialists seeking accreditation in Australia, but simply to increase the number of surgeons available to be tested for compliance with the Australian standards’.

Assessment of overseas-trained specialists

11.124 Mayne submits that:

• attracting overseas-trained specialists is a ‘time and cost effective way to increase the number of specialists available to practise in Australia… However, the need to attract overseas-trained specialists must be balanced against the need to ensure that the standards of care that underpin the Australian health care system are not diminished and, importantly, that the same standards are applied consistently throughout Australia’;

• ‘there are less restrictive ways in which these objectives can be achieved… for example, expanding the medical schools and qualifications that are recognised for the purpose of an exemption from Part 1 of the College’s examination and assessment program would increase the number of surgeons available to be tested for compliance with Part 2 of the College’s examination and assessment program’;

- Mayne considered that medical schools in the United States, such as Harvard, would comply with the standards required for exemption from Part 1 and should therefore be covered;

• the difficulties experienced by overseas trained specialists in obtaining accredited training positions also limits the number of these specialists who are available to complete Part 2 of the College’s training program(discussed below); and
• a significant component of any assessment program should provide that overseas-trained surgeons are required to complete at least some practical training in Australian hospitals.

Accreditation of hospital training posts

11.125 Mayne submits that:

• ‘as it is the College that accredits the training posts in hospitals, the number of trainees who can participate in the Australian Training Program is determined by the College to a significant extent’;

• ‘the number of accredited training positions is insufficient to provide adequate coverage of public hospital patients resulting in unaccredited positions being funded by the state system. The unaccredited positions are filled by trainees until they are able to obtain an accredited position and commence their specialist training... While the salary and supervision costs of the unaccredited positions are the same as the accredited positions and there is no real difference in the breadth of experience given to the trainees, the unaccredited positions are not recognised by the College, and so training completed by a trainee in an non-accredited position is not taken into account’;

• while it is necessary and appropriate for candidates to meet appropriate, objective criteria before being entitled for Fellowship, there is no legitimate reason why artificial restrictions should be placed on the number of candidates who are eligible for assessment in accordance with this criteria’;

• ‘it is possible to increase the number of surgeons, while ensuring that only those surgeons who have the highest standards of knowledge, skill and expertise be entitled to practice surgery in Australia’;

• this can be achieved by ‘converting existing unaccredited positions to accredit positions by accrediting a larger number of positions’.

Concerns regarding increasing the number of specialists

11.126 Mayne submits that:

• ‘some parts of the industry are concerned that an increase in the number of surgeons will lead to an increase in the demand for their services. This does not mean that the appropriate way to address the issue is by directly limiting the number of surgeons’.

• ‘in any case, it has been recognised by AMWAC… that there will be a shortfall in the optimal number of surgeons, especially in some of the sub-specialties’;

• ‘further, the demand for medical services in Australia is increasing as a result of improvements in technology that allow for the earlier, better and more accurate diagnosis of disease; improved consumer awareness of disease and its management; and an increase in the availability of definitive treatments for an increasing number of ailments’;

• ‘there needs to be an increase in the number of surgeons available to practice in
Australia. The Australian health care system is regulated in a number of ways which enables the industry to increase the number of surgeons while ensuring that this increase in supply of specialists does not drive demand. In particular:

- to access the specialist rebates under the Commonwealth Medicare Benefits Schedule, a patient is required to obtain a specialist referral from a general practitioner. There are a number of obligations imposed on general practitioners to ensure that referrals to specialists are appropriate and do not amount to an abuse of the health care system; and

- private and public hospitals are required to obtain hospital bed licences. This limits the number of patients that can be treated within the health care system, and imposes an effective control on the demand for hospital services’.

11.127 Mayne also proposes:

- ‘ensuring that the College determines the number of trainee positions based on the demand for particular specialties in relevant regions in Australia’;

- ‘expanding the rural training program for general surgeons established by the College to cover other specialists’.

**Australian Health Insurance Association Ltd**

11.128 While the Australian Health Insurance Association (AHIA) believes that it would be appropriate for the College to continue in its present role as the training and examining body for surgeons in Australia’, it considers that ‘it is doubtful [whether] authorisation should be granted’ for the College’s processes in hospital post accreditation, trainee approval or hospital appointments.45

11.129 In particular, AHIA submits that:

- ‘in so far that the College determines the accreditation of funded posts and the approval of trainees, it could not be said that it plays an insignificant role in determining the actual number of trainees, and hence, the number of surgeons, in Australia’;

- the Royal Australasian College of Physicians does not approve trainees to undertake training;

- the College accredits some posts while other similar posts are not accredited. ‘This differentiation is understandable where the non-accredited position is deemed deficient in supervision, hours worked, theatre time allocated, patient numbers or the breadth and depth of its learning potential. However, where there are two identical posts, often in the same surgical unit in the same recognised hospital, with identical patient mix and numbers, theatre time, supervision and hours, it is unclear why one should be accredited and the other not’.

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45 The College’s application does not extend to hospital appointment processes.
11.130 AHIA agrees that the College’s claims that there is limited price competition between surgeons and that they generally charge within 15 per cent of the Medicare rebate may be true for out-of-hospital services.

11.131 However, the AHIA argues that prices for in-hospital services are significantly higher and therefore ‘price competition among surgeons is significant’. In particular, the AHIA submits that:

- the average surgical fee in the first quarter of 2001 was approximately 40 per cent above the Medical Benefits Schedule, with 50 per cent and 60 per cent above the Medical Benefit Schedule being the norm for orthopaedic and ophthalmic surgery respectively;
- health insurance fund members ‘do not normally have access to information which would allow them to make a decision based on the relative skill of individual surgeons… thus, price may be a critical component of member decision-making’; and
- ‘where numbers of a certain discipline are few, their average fees are higher… for example, in South Australia, surgical fees are generally lower than in Victoria. Where they are higher, ie in neurosurgery and hand surgery, there are significantly fewer providers relative to other surgical disciplines than in Victoria, even allowing for differences in population’.

11.132 The AHIA considers ‘the notion of supplier induced demand and the related effect of co-payments may be valid for non-referred services and for specialist consultations (where the patient requests the specified referral from their practitioner, rather than the latter recommending the service)’. However, it considers supplier induced demand is ‘less likely to be valid for admitted surgical procedures’. This is evidenced by the fact that the ‘wide prevalence of no gap services (effectively increasing supply as well as removing co-payments) has not significantly increased the utilisation of admitted services’. Generally, it considers that the notion of supplier induced demand ‘should not detract from the importance of supply to price’.

11.133 The AHIA also submits that:

- ‘applying a strict market-based approach to the College’s services may be flawed;
- the central values of medicine may be more important than economic considerations in this market’; and
- ‘it is not necessarily true that consumers… cannot be adequately informed so as to make informed choices. The modern role of College Fellows should not only involve making sound professional judgements but should not also involve the provision of information to the patient so that they to may participate in those judgements’.

Medibank Private

11.134 Medibank Private is the largest private health insurer in Australia. It considers the College’s submission is a fair and accurate representation of the processes currently in place. It also agrees that responsibility for funding training positions rests with
federal, state and territory governments.

11.135 Medibank Private states that it is important for the whole of the private health insurance industry to ensure that measures are put in place to ‘assure that the continuation of adequate numbers of training positions [is] facilitated’. It also considered that a ‘professional review and assessment mechanism [should] be put in place to assure that the most suitable people are accepted into training programs’.

**Johnson and Johnson**

11.136 Johnson and Johnson is the world’s largest supplier of health care products and services.

11.137 It submits that:

- ‘irrespective of the specialty, there is no way to ascertain the competency of a medical practitioner/clinician without some form of practical assessment involving actual patients and close supervision’; and

- ‘Australian surgeons are highly regarded throughout the world… this is due in no small measure to the processes and approaches the College adopts toward training and accreditation… [I] fully endorse their adoption’.

**Calvary Health Care ACT**

11.138 Calvary Health Care ACT (Calvary) made the following two comments, which apply to all specialist medical colleges:

- ‘as the recognised training body whose criteria must be met by trainees and hospitals that employ trainees, the College’s training requirements must be realistic. It would not be appropriate if a College was to set criteria for training that most hospitals could not meet and/or thus restricted the number of trainees who could be appropriately employed in an approved hospital’;

- ‘the College should not specifically determine the number of trainees allowed into the training schemes or the number of trainees that could be employed by a specific hospital. If an approved hospital can fulfil the training requirements then that hospital should be free to determine the number of trainees it needs to employ’.

**Consumer associations**

**Australian Consumer Association**

11.139 The Australian Consumers Association (the ACA) opposes authorisation of the College’s arrangements.

11.140 Instead, it favours ‘measures which would increase the supply of surgical services. These would include reduced barriers to entry to the profession, with some institutional separation of the functions of standard setting, accreditation, training and examination. [It] would also welcome innovations which could see more routine surgical tasks performed by suitably qualified medical practitioners with a more
focused, lower cost training’.

Barriers to entry

11.141 The ACA submits that:

- ‘surgical training, by its very nature, has high barriers to entry. It is an expensive personal commitment for someone aged around 24…for young women considering starting a family, the barrier is close to absolute’;

- while the market for surgery exhibits aspects of market failure (for example, ‘competition based on perceived quality and reputation rather than price; complexities facing consumers in acquiring knowledge of health care choices’), it fails to see why this ‘should justify the… maintenance of tight barriers to entry. Indeed, we contend that such intrinsic market failure makes it all the more important for those aspects of the market which can be subject to public policy to be as open as possible’;

- the College’s argument that ‘it is but a passive actor’ as regards the number of hospital training posts has three flaws:
  - ‘while it is correct that governments are hard-pressed to fund training places, this does not mean that other barriers to entry can be ignored. Indeed it would be futile for the government to fund more training places if there are not enough people coming through the supply chain’;
  - the ‘argument is circular. Training obviously requires supervision by qualified surgeons, but if there is a general shortage of surgeons, then there will be a general shortage of supervisory capacity’; and
  - ‘it is not clear that the College’s present arrangements are the best for providing surgical services…it makes sound economic sense to allocate the more routine surgical tasks to people with shorter, specific training…with experienced surgeons relieved of some of their more routine tasks, they should have more capacity for training and supervision’.

- the supply of surgeons in Australia is restricted. It states that it ‘has no reason to depart from the findings in the Baume Report, which found there to be excessively tight control of the supply of trained surgeons…indeed the evidence suggests supply is even tighter than it was when the Baume report was published’. In particular, it notes that:
  - ‘between 1995 and 1998 there was no increase in the number of surgeons in training’;
  - ‘for specialist services and operations…fees charged have increasingly become de-linked from the [Medicare] schedule fees, rising by 5 per cent relative to the schedule fee for specialists, and by 7 per cent for operations over the ten years to 1999’; and
  - ‘a third of all surgeons report themselves to be working more than 64 hours a week; 15 per cent report working more than 80 hours…surgeons are ahead of other medical professions by a long way…extremely long hours are [also]
indicative of high safety risks… for all specialists, the proportion working 80 hours or more has risen from 5.6 per cent in 1995 to 8.8 per cent in 1998… shortage of numbers, coupled with high hourly remuneration resulting from this shortage, is the most compelling explanation’ for these working hours.

Public benefits

11.142 The ACA submits that:

- ‘while we do not deny the existence of public benefits, we question their magnitude’

- the claim ‘that College members contribute $230 million annually in pro-bono work… seems to be a high figure considering there are only around 650 surgeons in training – $350,000 per student!’

- in any event, ‘in the spirit of mutual obligation, those who have benefited so greatly from a publicly subsidised education should be expected to return something to the community on a pro-bono basis’; and

- the College’s submission does not establish that ‘these benefits could not be achieved in a much more competitive market… in a more open market… some of these benefits may have to funded in different ways because competitive pressures may reduce the opportunity for pro-bono work… the benefits of a more open market would easily outweigh the costs associated with the need to find alternative ways of funding these services’.

Community Relations Commission for a Multicultural NSW (formerly the Ethnic Affairs Commission)

11.143 The Community Relations Commission for Multicultural NSW (CRC) does not support the authorisation of the arrangements as they stand. The CRC’s submission focuses on the processes for assessing overseas-trained practitioners.

11.144 The CRC would support the development of clear assessment criteria by the College (and other specialist colleges) in the assessment of overseas-trained specialists. It considers that these need to be publicly scrutinised and independently assessed to ensure they are not anti-competitive and against the public interest.

11.145 The CRC refers to the Race to Qualify Report of the Committee for the Review of Practices of the Employment of Medical Practitioners in the NSW Health System, October 1998 (Race to Qualify Report). That report found that the differences in assessment and registration requirements and employment and training opportunities for permanently resident overseas-trained doctors, temporary resident doctors and local graduates are not based on medical standards, and indicate unfair and anti-competitive policies. The CRC submits that College procedures critically impede the registration of world acclaimed doctors upon their permanent residency in Australia.

11.146 The CRC considers that there are two standards of assessment for permanently resident overseas-trained doctors and temporary resident overseas-trained doctors. It

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submits that harsher rules are applied in a process established to assess permanently resident applicants for specialist recognition. Statistically, permanently resident applicants are far more likely to be from non-English speaking backgrounds. It submits, in agreement with the findings of the Race to Qualify Report, that this practice is potentially racially discriminatory.

11.147 The CRC questions why overseas-trained specialists cannot work under supervision whilst receiving training in areas where their previous training has not been the same as Fellows from Australian specialist colleges. If their qualifications are narrower than those of an Australian trained specialist, it is not clear why they cannot continue to work with the same conditions placed on their registration, or why the colleges and medical boards have not pursued such changes.

Medical schools

Committee of Deans of Australian Medical Schools

11.148 The Committee of Deans of Australian Medical Schools (CDAMS) strongly supports authorisation of the arrangements.

11.149 In particular, CDAMS submits that:

- there is no other organisation capable of training and examining surgeons in Australia;
- ‘universities are not equipped or resourced’ to undertake this function and ‘have not expressed any interest in establishing vocational training programs in their own right’;
- ‘shortfalls in targets are due to the inability/unwillingness of hospitals to create new training positions or (in a small number of surgical specialities) low demand for posts by potential trainees’; and
- the system used by the College to assess overseas-trained practitioners ‘is in the interests of equity and fairness to all applicants, and is probably unnecessarily cumbersome for certain types of appointments (for example, appointments to senior academic and/or major public hospital positions where considerable credentialing and referencing has already taken place as part of the appointment process)’.

University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences

11.150 The Faculty of Medicine, Dentistry and Health Sciences supports the application for authorisation.

11.151 In particular, it submits that:

- the AMC accreditation process will ensure that the College’s processes are ‘conducted in accordance with the laws of natural justice and with the Trade Practices Act’;
- it would not be possible to replicate the functions of the College without ‘the risk of lowering standards to a level unacceptable to the public or at a much greater
public cost. In particular, universities are not in a position to offer an alternative or competitive process of training… they lack a national jurisdiction and do not have the workforce available to implement competitive training and certification programs at the postgraduate level’; and

- ‘many senior clinical academics within medical schools also [hold] senior positions within colleges. This type of integration of activities is totally desirable and again cost-effective and in the public interest’.

University of Sydney, Faculty of Medicine

11.152 This submission mirrors that provided to the Commission by the CDAMS.

The University of Western Australia, Faculty of Medicine and Dentistry

11.153 The Faculty of Medicine and Dentistry submits the training of surgeons is determined by a number of stakeholders and not exclusively the College. It submits the major factor restricting the number of training positions is the ‘belief by some that increased numbers will increase the medical costs to the community’.

11.154 The Faculty submits that the College and trainees contribute an enormous amount to its teaching program as well as to hospital activities and communities. It submits there is potential for considerable loss of good will if this is not recognised.

The University of New South Wales

11.155 The University of NSW supports the submission from CDAMS.

11.156 However, it makes an additional point in respect to the College’s processes for assessing overseas-trained practitioners. Namely, that greater exposure is required in relation to how the College assesses the credentials and training of overseas-trained surgeons. The University has had difficulty attracting academic staff suitably qualified to appoint to academic positions in Departments of Surgery. It submits that this is partly due to the difficulties in gaining credentialing approval from the College via the NSW Medical Board of the suitability of such individual’s training. The University would therefore favour further examination of this matter. Whilst it understands that the College does have explicit ways of making such evaluations, it submits that the College has not provided enough detail to allow evaluation on a case by case basis of whether such evaluation is reasonable.

Other

11.157 The Commission also received two complaints from individual medical practitioners in relation to gaining selection into the advanced surgical training with the College and College interview and examination practices.

11.158 In addition, the Commission received a submission from the Australian Doctors Trained Overseas Association (ADTOA). The Association submits that individuals in NSW who have been registered by the NSW Medical Board, are also denied Fellowship of the College. However, under the legislation, it is the relevant specialist medical college which recognises the qualifications and experience of the individual in order to gain registration.
11.159 The ADTOA submits this practice ‘…restricts competition in the public hospital system, where the practice exists that to obtain a specialist appointment requires ‘Fellowship’ or at least absolute priority is given to Fellows of Australian specialist colleges’.