Summary

The Royal Australasian College of Surgeons thanks the National Health and Hospitals Reform Commission for undertaking such a vigorous stakeholder consultation and we thank the Commissioners for providing the College with an extension to the submission deadline. This is a once in a generation opportunity to build on the current strengths in many components of our health system and to make substantial improvements.

The College has identified 13 areas in our submission which it believes are worthy of discussion in terms of the commission's review process. They are:

- service design and governance principles;
- funding accountability;
- outcome accountability;
- quality accountability;
- preventive health activities;
- indigenous health;
- respectful ethical systems;
- technology and research;
- targeted workforce;
- training;
- acute services;
- regulatory red tape; and
- clinician involvement.

A pragmatic, outcome focussed approach is required if Australia is to achieve change which will benefit the community's health and the overall health system.

Our submission highlights the importance of a single funder model of healthcare to improve responsibility and accountability. The College has also stipulated far greater involvement and acknowledgement of the substantial role of the private sector.

Page two of our submission focuses on the importance of outcome based measures in order to see definite improvements in health. It is important that responsibility for health improvement must be shared between individuals, the community and government.

The College believes that preventive health initiatives need to be properly funded, but not at the expense of acute care. For too long funding has been transferred from acute care to preventive medicine in the mistaken belief that preventive medicine will "decrease illness".

The section on quality highlights the College's commitment to compulsory peer review and audit and argues for sufficient government funding to ensure that this occurs appropriately.

Page four of our submission argues for a review of work practices across Australia. Our submission calls for performance indicators that are matched with efficiency measures. We emphasise that while task transfer has the potential for effectively extending the delivery of health care, it must be carefully managed.

As a surgical training body the College has identified that increased training expectations will require dedicated and remunerated time with a greater skill mix in those undertaking the training and educating. In addition, increased numbers of trainees in the future will require the private sector to be more highly involved in the training of specialist medical practitioners.

In the acute services section, the College points out that access to acute and emergency surgery is one of the greatest health issues in Australia today. It is imperative that elective surgical services should be quarantined from acute services to provide more efficient and predictable patient outcomes.

Finally, our submission concludes by noting that if any of the commission's recommendations are to be successfully managed and implemented then clinicians must be involved.

RACS Submission to National Health and Hospital's Reform Commission

Background

The Federal Government is to be congratulated on the initiative to create a commission to develop a long term health reform plan for a modern Australia.

This is a once in a generation opportunity to review the current health structures and make bold suggestions to re-fashion our systems. Australia delivers health services in a way that is the envy of many countries but can still be significantly improved. The College is highly conscious that the commonwealth and state governments have also committed to a new federalism that could see the streamlining of systems and responsibilities to the benefit of all.

There is now a unique political opportunity to build on the current strengths in many components of our health system and to make substantial improvements. The importance will be to define the strengths of which there are many so they can be continued. However, the stresses in the system are considerable and it is time to be both bold and brave.

Service Design and Governance Principles for Australia's Health System

The College acknowledges the commission's principles as a comprehensive approach to viewing the health care system. The issue that we wish to highlight is that pragmatic solutions are required to deliver the aspirations of the principles. Their delivery will achieve change for the benefit of the community's health and the health system.

Equally the College will highlight the issue of accountability. There is much truly preventable ill health in Australia. This can be tackled but only if the political will and community aspirations can be aligned. In particular indicators of performance need to move from being process indicators to far more rigorous outcome measures. There is now substantial evidence that health care assessment requires measures of structure, process and outcome to be used in combination.

The College acknowledges that the interim report *Beyond the Blame Game* addresses more of the concerns relating to the Australian Health Care Agreement rather than establishing a blueprint for the future. The time frames for the AHCA do not allow proper deliberation of the core changes that must be achieved in our current health model.

Tinkering at the edges for an improved AHCA process would miss the opportunities as outlined above. The Commission needs to continue to provide a blueprint that is meaningful. This particularly applies to full use of the private sector. The model for the future needs to enable a state based health minister to have a good understanding of and capacity to work with the private hospital sector even if the funding for this area is with an agency of another government.

Accountability for funding

Many models have been discussed that could achieve greater efficiencies within the health sector. The College has long been a supporter that all the health system should be fully federally funded with the responsibility and accountability residing with the federal minister. The College and a number of its associated specialist societies still strongly believe that only by having one funder will accountability and responsibility be substantially improved. However the College recognises the constitutional and political challenges of this. Whatever the model achieved there needs to be minimal cross-over between funding streams to achieve optimal care.

As an example oncology patients currently move between public and private hospitals, outpatient services that may be federally or state funded to ensure they can access clinical care, diagnostic services and therapies such as pharmacy or radiotherapy in the most time effective manner. Disjointed services or lack of ability to access key services is detrimental to the patient's care and their clinical condition. They should be able to source their required services promptly, with least administrative burden and preferably in one location.

The model as proposed in *Beyond the Blame Game* still appears to split accountability between different governments. Private hospitals do not appear to be meaningfully included. If the funding follows the patient type (eg acute, aged or mental health) regardless of location, the situation would be improved but only marginally. To be admitted into the acute sector and then transferred to another service from another funding type is time-consuming and would accentuate the ongoing shortage and access to alternative accommodation types. Achieving the right balance between the public and private systems is crucial.

The model with least amount of possible cost shifting will end up the most effective.

The College supports a single funder model of health care to improve responsibility and accountability.

Accountability for outcomes

Responsibility for health resides with the individual, the community and with government. If health is going to be substantially improved then the affected groups need to accept their share of responsibility.

There have been decades of action in preventive medicine. Much of it has been highly successful and good sanitation, vaccinations/immunisations and adequate nutrition have been the most effective health advances in the last 50 years. However an analysis of today's health problems highlights that the individual must be accountable for health outcomes. Communities need to accept health outcome based goals rather than exclusively highlight activities in further prevention and screening programs.

There is no doubt that breast screening and colo-rectal cancer screening need continued encouragement and funding. Other cancer screening could be appropriately funded. However the most definite improvements in health would be obtained by accepting the following goals.

1. road related mortalities to decrease by 10 % per year.
2. acute brain injuries to decrease by 10% per year
3. the percentage of people smoking to decrease by 10% per year and the number of people less than 25 years of age who smoke to decrease by 20% per year.
4. the number of people with a BMI > 25 to decrease by 10% per year

A number of other measures could equally be created. However by public health, legislative and preventive health initiatives all of these could be achieved. If Governments and the community accept these goals then real change can occur. These are the goals that will improve the health of Australians and possibly decrease our total health expenditure.

Health outcome goals need to be accepted by the individual, community and government. An example is road related mortalities and acute brain injuries need to decrease by 10% per year.

Preventive Health Activities

As highlighted above the preventive health activities need to have definite outcomes to be measured. Relying on process or uptake measures only gives comfort that activity is occurring – not necessarily an outcome is achieved.

The preventive health activities need to be properly funded and must be separately funded from the acute health sector. For many years funding has been taken from the acute health sector and put into these valuable initiatives as it will "decrease illness" but the acute sector is already under funded. Preventive health initiatives are not decreasing the incidence of acute illnesses, although they may be changing the spectrum of disease. The funding is needed in the acute sector now.

Dedicated funding is needed for preventive health activities that is additional and separate to acute health funding.

Indigenous Health

The gap in health outcomes between the Aboriginal and Torres Strait Islander population and the Australian population overall is a national tragedy. The College supports all initiatives designed to address these concerns. However we note that these initiatives are usually social, public health and chronic disease orientated. The College strongly supports the training of health professionals from the Aboriginal and Torres Strait Islander populations as this will be the key to the successful policy outcomes.

Accountability for Quality

The quality of the health service is the responsibility of all the providers both individually and collectively. The systems are becoming more complicated on a daily basis as services become more specialised, more involved and based in a greater range of clinical areas.

Ongoing reports of adverse events describe how up to 10% of patients may suffer an adverse event while in hospital. To improve this requires an ongoing commitment to review and systems improvement. The resources and funding need to be made available by government to allow appropriate audit and review. This audit and peer review needs to be driven by strong local processes to ensure it is risk adjusted and issues are properly addressed.

Mortality audits on a national basis are critical as are gathering a small number of relevant clinical indicators. The College is a strong supporter of peer review and audit and believes this should be compulsory. Equally mortality audits should be a compulsory requirement for all clinical activities in hospitals. Risk adjustment and local hospital differences often make national comparison of clinical indicators invalid. Resources should be applied as a priority to support audit and peer based review.

Respectful Ethical Systems

Ethical issues in hospital often deal with whether a particular treatment should be undertaken. Perhaps the most significant ethical issue confronting hospitals is the reliable introduction of advance clinical directives to ensure what level of care is appropriate. Excessive and thereby inappropriate care is often provided to the elderly and the ill when careful discussion before life critical events would have given far better understanding of the supportive care required. Elderly residents of nursing homes have an expectation of receiving their care in that environment. A very substantial percentage is inappropriately transferred to an acute facility for their terminal care.

Even more worrying is the percentage of these people who are then operated on or receive care in intensive care beds or high dependency units. Clear directives and understanding by the families would ensure better and more compassionate care.

Ethical systems ensure that appropriate care is provided.

Screening of Technology and Research into Health Systems

The College has been undertaking the assessment of emerging surgical technologies for 10 years through the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). Funded by dedicated federal government funding the preferred methodology of introducing technology is now clearly understood and many new initiatives are carefully reviewed before their broader introduction. This is critical to ensure the standards of patient care are maintained and appropriate training and review of clinical practices are achieved.

The activities of ASERNIP-S now extend beyond the surgical domain and can be readily extended further to the broadest context of clinical and diagnostic situations. Importantly there should also be research of the health systems. In Australia much research is appropriately devoted to the biomedical sciences model. However the delivery of care, the interaction between groups and the environment where this is undertaken should all be appropriately researched. This is rarely funded in the Australian health system and should be to ensure ongoing improvements. Resources should not be wasted on ineffective systems.

Funding for Research and Technology assessment is critical for the future health and financial performance of our health system.

Enough of the right people doing the right work

The health system relies on the maintenance of standards across the various professional groups to perform at the level it does. The College is one of the essential groups to ensure the standards are identified and that professionals are trained to this level. The training program of the College and associated specialist societies deliver high quality professionals. However, standards are almost “assumed” within the Australian context and this often brings a temptation to allow them to be broken down. Clinical misadventure and tragedy are reminders of this essential role which the Colleges play with employers and medical boards across the country. Equally, hospitals and employers need to be conscious of standards in all credentialing and appointment processes.

There is substantial room for review of work practices across Australia. It would be most important that performance indicators are also matched with efficiency measures. For example, the College of Surgeons remains most concerned as to the lack of availability of operating theatres and operating time due to the inefficiency of the systems. Comparisons should be made between the public and private sectors on fundamental management issues such as operating theatre access, throughput and staffing profiles. Although there may be an increased demand for surgeons into the future with the ageing population there is an enormous capacity to increase throughput if efficiencies were optimised.

Surgery is now conducted within the environment of a clinical team with the surgeon as the lead. Greater importance is now being placed on physician assistants to ensure the appropriate administrative work is done in the most effective manner. The specialist clinician can then concentrate on the areas where their skills are required. Task transfer has the potential for effectively extending the delivery of health care but must be carefully managed. Proper training, appropriate delegation of responsibility and supervision are essential. Some of these models of surgical teams have been in place for a number of years in the United States of America and the United Kingdom and are currently being trialled in South Australia and Queensland.

Standards are not a given. They are based on high quality training, assessment and ongoing professional development.
More needs to be done to improve and sustain access to our current infrastructure.
Comparisons between the public and private sectors are important.

Training the workforce of the future

The Colleges have an essential role in the vocational training of professional medical specialists. Historically based on an apprentice model and with pro-bono contribution the increased regulatory and educational requirements are now highlighting the commitments required.

Increased expectations will require dedicated and remunerated time with a greater skill mix in those undertaking the training and educating. Training is now being undertaken in a broader range of environments with the expectation that skills will progressively be learnt and assessed in artificial environments as well as under close supervision in the operating theatre. Training time, the investment in infrastructure and the increased surgical work to support the training are important issues to be addressed through funding. The number of trainees is directly related to this.

Clinical training is still strongly based on an experiential model. Increased numbers of trainees in the future will require the private sector to be more highly involved in the training of specialist medical practitioners. This will require the private facilities to have funded infrastructure, the trainers to have their time recognised and an understanding between the clinicians and their patients about the increasing involvement of trainees.

Training requires infrastructure particularly in ongoing service provision. This can occur in both public and private sectors.

Access to Acute Services

Access to acute and emergency surgery is one of the greatest health issues in Australia today. Critical mass, work life balance and realistic after hours rosters make the availability of surgical services more restricted.

If a population of 50,000 is required to provide a fuller general surgery service then remote and regional areas need to access clinical services in a different way. Other specialities would require a greater population base. Politically it is difficult to balance the issues of access to quality and sustainability of service.

Equally for acute services to be provided they need to be resourced in terms of theatre availability and hospital resources so the work can be reliably undertaken. Acute surgery cannot be undertaken at midnight on an ongoing basis without burn-out of staff and some danger to patients. Elective surgical services should be quarantined from acute services to provide more efficient and predictable patient outcomes. Access to surgeons in the hospital with availability to theatres in a very prompt manner is essential for more reliable emergency surgery.

Elective waiting lists are measurable and because of this continue to be both a political and health care concern. It is critical that waiting measurements also capture the time that the local general practitioner refers the patient to the specialist. Artificial waiting lists often ignore the outpatient wait or provide other hurdles as well as the time to admission. It is important that all the delays are realistically revealed and monitored.

In the suggested performance indicators in *Beyond the Blame Game* the categories that previously described the severity of patient conditions appear to have been changed. It will be critical that any changes are clinically validated. It is noted that cancer patients and

cardiothoracic patients are termed as Category 1 with their specific priority. Other patients who have life threatening or very painful conditions as well as patients who will undergo irreversible quality of life reduction are also urgent and need to be included in the descriptors.

Acute service access needs dedicated and committed resources, preferably separate to elective surgical work.

Providers of Health Care and regulatory red tape

In the consultation and implementation processes it is important to remember that most of our health services are still provided in the community by health practitioners in a small business model. Although the hospital provider, the hospital chain and at times the health insurers may have very definite requirements many of the services are provided away from this environment.

In particular the day surgery providers have substantial regulatory requirements for the provision of their services. Much of this is required but the myriad of accreditation bodies and regulatory/reporting bodies that require data submissions increases the costs of providing the services without improving the quality or range of service. The efficiency of the health services can be substantially improved by streamlining these requirements.

Regulators and accreditors need to be consolidated to reduce red tape and costs and improve efficiency.

Involving the Clinicians

The National Health and Hospitals Reform Commission can develop an enormous agenda of meaningful change. The implementation of this across the country will be a critical phase. The recommendations need to be pragmatic and connected with solutions. The management of the implementation needs to involve the clinicians. Other countries successfully involve the clinicians actively as managers and also fund-holders. However whatever the funding model, without clinical involvement the change management program will be more difficult and the outcomes possibly illusory.

Meaningful change always involves the stakeholders. Patients are critical, funders are essential but the clinicians need to understand and own the path forward. The College of Surgeons has the experience and capacity to offer ideas and solutions to the commission and is ready to contribute further.