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Submission to the Senate Select Committee on Health

Author: Australian Society of Anaesthetists

PO Box 6278, North Sydney, NSW 2059

02 8556 9700

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Senate Select Committee on Health

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Submission finalised by Dr James Bradley of the ASA Professional Issues Advisory Committee (PIAC), Endorsed by Dr Richard Grutzner as President and on behalf of the ASA.

t 02 8556 9700 | f 02 8556 9750 | asa@asa.org.au | www.asa.org.au | ABN 16 095 377 370
PO Box 6278, North Sydney, NSW 2059

Senate Select Committee on Health

The Australian Society of Anaesthetists (ASA) notes that on 25 June 2014, the Senate resolved to establish a Select Committee into Health to inquire into and report on health policy, administration and expenditure, and provide a final report to the Senate on 20 June 2016.
The ASA has 3000 members and is the representative body for anaesthetists in Australia. This submission is on behalf of what is a hospital-based specialty, which provides acute healthcare to both Medicare and partially Medicare funded (that is, 'private') patients.

The terms of reference relate to:

a. The impact of reduced Commonwealth funding for Medicare services provided by State and Territory governments, including the impact on elective surgery.
b. The impact of additional costs on access to affordable health care and the sustainability of Medicare.
c. The impact on health promotion, etc.
d. The interaction between elements of the system including aged care.
e. Improvements, including indigenous health and rural health.
f. Better integration and coordination of Medicare services.
g. Health workforce planning.
h. Any related matters.

The ASA understands that the impact of reduced Commonwealth funding (a) and impact of additional costs (b) is being addressed by the 'whole of profession' representative body – the Australian Medical Association. The ASA will not be offering comment on (c), (d) and (f), given that we are an acute sector, hospital-based specialty.
Our submission to the Select Committee will address:

e. Improvements including indigenous health and rural health, and
f. health workforce planning.

In relation to improvements including indigenous health and rural health, the ASA advises that the latest report of Health Workforce Australia (HWA2025) into the medical specialty workforce identified a 'maldistribution' of anaesthetists in nonmetropolitan areas. A shortage of anaesthetists in these areas would be likely to have an adverse effect on indigenous and rural health.

The ASA recently surveyed anaesthetists in relation to their perceptions of the adequacy of the workforce in metropolitan and nonmetropolitan areas. The findings of the survey are as follows:

- In relation to urban areas with a population greater than 1 million, 71% of anaesthetists actually practising in those areas responded that there were too many anaesthetists and 16.5% said there was an appropriate number.
- In relation to urban areas with a population of 100,000 to 1 million, 39.1% of anaesthetists actually practising in those areas responded that there were too many anaesthetists and 36.8% said there was an appropriate number.
- In relation to urban areas with a population of 10,000 to 100,000, while 9.4% of anaesthetists actually practising in those areas responded that there were too many anaesthetists, 32.4% said there was an appropriate number and 45.9% an inadequate number.

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The ASA believes, therefore, that there is likely a relative shortage of anaesthetists in urban areas with a population of 10,000 to 100,000, but that the existing anaesthesia workforce in these areas is able to manage the existing caseload. This latter assertion is underwritten by research showing that only 14.1% of anaesthetists in urban areas with a population of 10,000 to 100,000 felt that they were unable to increase their caseload.

The ASA also believes the situation will be addressed in the short-term given that, when young anaesthetists were asked whether they had moved from a metropolitan region to a rural or remote region, or had worked in a rural or remote area to obtain an 'adequate' anaesthesia case load, 7.3% of younger members as opposed to 1.2% of established anaesthetists stated that they had made such a move.

In summary, the ASA believes that the 'maldistribution' of anaesthetists identified by Health Workforce Australia has no current adverse consequences on the provision of services in nonmetropolitan areas, with the number of anaesthetists in those areas being augmented by the movement of specialists within the existing specialty workforce. Accordingly, the ASA does not identify any current adverse effect on indigenous and rural health.

Furthermore, it needs to be emphasised that it will never be possible to provide the comprehensive high-level specialty services seen in metropolitan areas in rural and remote areas, such as those serving a population of less than 10,000 people. A local population of about 30,000 people is estimated by the ASA to be the minimum that would underwrite the provision of a basic sustainable resident local anaesthesia workforce. Those Australians that do reside in remote areas require properly resourced retrieval services to enable their early transfer to medical facilities in larger urban areas. This can be facilitated by the presence of medical practitioners with unique generalist skills in areas with a population of less than 10,000 people. The attention of the Committee is directed to the endeavours of the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine.

In relation to health workforce planning, the ASA advises that there is concern within the specialty that too many anaesthetists are being trained. It is felt that the current ultimate determinant of the number of trainees in anaesthesia is the need by State Departments of Health for a particular specialist/trainee service provider mix that delivers Medicare funded acute-care services; and that this mix is unrelated to any properly researched consideration of the number of future providers required in the non-teaching hospital sector. The early work in this area by the National Medical Training Advisory Network (NMTAN) is however, noted.

A consequence of the training of too many specialists in anaesthesia is that, on completion of training, given the lack of employment opportunities within the public teaching hospital sector, young specialists may be obliged to enter private practice as a default employment option. An immediate consequence is that young specialists may be relatively under-employed and as a consequence, fail to continue to develop skills.

ASA research has asked young specialists in anaesthesia if they felt if their current case mix/practice profile was adequate for the purposes of maintaining skills in anaesthesia. The current case mix/practice profile was stated to be inadequate for 21.7% for members within five years of commencing practice, compared with

14.3% for all anaesthetists. The implication is that an oversupply of young specialists can lead to an under skilling, which would have adverse effects for the Australian community. Further research has identified that relative underemployment may also lead to working outside one's 'comfort zone', this also being detrimental to both patient and practitioner.

Considering the broader specialty in the context of a possible oversupply of specialist anaesthetists, anaesthetists were asked whether they could increase their professional caseload. Eighty-two percent of younger members and 74% of older anaesthetists stated that they could increase their caseload with no difficulty or some difficulty. This would indicate that there is spare capacity within the specialty.

The Australian Society of Anaesthetists believes, therefore, that there may currently be a relative shortage of anaesthetists in urban areas with a population of 10,000 to 100,000, but believe (as stated above in relation to indigenous health and rural health) that this deficiency will be solved shortly.

It seems, based on the evidence available, that it is likely that more anaesthetists than required to meet community needs are being trained and that this is to the potential detriment of both anaesthesia specialists and the community. The ASA believes that the HWA report into the anaesthesia workforce contained within the HW2025 report is flawed in that insufficient input was sought from the 'grassroots' specialty, as represented by this organisation. It is to be hoped that this deficiency will be corrected by NMTAN.

The ASA looks forward to the opportunity to expand on its views to the Select Committee on a future occasion.

Yours faithfully,

Dr Richard Grutzner
President.

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