Australian Society of Anaesthetists

PO Box 6278, North Sydney
NSW 2059, AUSTRALIA
t: 1800 806 654 | e: asa@asa.org.au
www.asa.org.au | ABN: 16 095 377 370

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By email: admin@asreview.org.au

Dear Accreditation Systems Review team,

ASA submission to the 'Independent review of accreditation systems within the National Registration and accreditation scheme for health professionals' Draft report September 2017

Reference: 1.3.10

The ASA welcomes the opportunity to respond to this draft report from Professor Michael Woods.

This ASA response is being submitted on the 16th October, 2017 as Australia celebrates National Anaesthesia Day. Australia is fortunate to have one of the best anaesthesia training programs in the world through the Australian and New Zealand College of Anaesthetists (ANZCA). Consequently, Australia is one of the safest places to have anaesthesia for surgery and other procedures. The recommendations in this report may be summarised as interfering with the independence of the specialist medical colleges and universities, compromising the training of specialist doctors such as anaesthetists, decreasing the quality and safety of patient care, increasing bureaucracy and introducing new costs. This would result in fewer resources being available for the delivery of education and healthcare, reduced cost effectiveness, increased out of pocket expenses for patients and decreased access to care for the most vulnerable in our community.

I. Independence

Currently the "Australian Medical Council's purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community."[1] Similarly "ANZCA's mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine."[2] These bodies determine training, education and accreditation standards for anaesthetists to ensure the public receives optimum care.

Introducing a 'Health Education Accreditation Board' as described in option 3[3] would seriously compromise the independence of the current arrangements. This would politicise professional accreditation making the system accountable to the political objectives of the government of the day over and above the interests of community quality and safety.

II. Quality and safety

The current professional accreditation system reflects the organic growth of various professions, craft groups and other healthcare providers. Providing integrated

interdisciplinary care requires collaboration across healthcare sectors and amongst healthcare workers.

The ASA is supportive of endeavours that increase the provision of cost effective, equitable, sustainable healthcare. These draft recommendations suggest homogenizing the important distinctive contributions made by different healthcare workers, which constitute the complex tapestry of modern healthcare.

Changing the current system without evidence that it will improve healthcare, risks compromising quality, safety and access to care. A one size fits all accreditation system may not actually be the best system. Expanding the scheme to unregistered professions may create confusion in the public's view about what to expect from their particular healthcare worker.

III. Task substitution

Since the Productivity Commission Report 2005[4], there has been a desire to reach a quick fix to reduce healthcare costs by reducing workforce costs through task substitution. For some tasks that can be delegated safely this makes sense and the ASA has a long tradition of working with general practitioners and nurses to provide safe anaesthesia care. However, having an accreditation body that seeks to reduce costs through interdisciplinary task substitution means utilizing a less experienced healthcare provider that will compromise patient outcomes. This reduction in standards is clearly not in the public interest.

Gladwell[5] describes the 10,000 hour rule where competency in complex tasks such as administration of anaesthesia, requires a long induction period. The collective flying hours experience in the cockpit of an A380 aeroplane is typically between 24,000 and 30,000 hours. Taking care of the passengers involves the important contributions of many people. From a risk management perspective, flying of the aircraft requires appropriately trained and experienced pilots. Pedagogical advances such as simulation-based learning and interdisciplinary crisis management have been successfully introduced in anaesthesia training and pilot training. This does not diminish the need for the appropriately trained people to deliver the right care at the right time to the right patients. The airline industry would not accept the legal risk of allowing task substitution for pilots. Would the government accept the medico-legal risk of allowing inadequately trained healthcare workers to provide less than optimal care because it is cheaper?

Proposals to reduce healthcare costs through reducing workforce costs is not cost-effective. There are over four million anaesthesia episodes delivered across Australia annually. Keeping patients safe is the prime priority. Errors in anaesthesia can have immediate and catastrophic personal, social and financial implications. The quality adjusted life years lost from the delivery of sub-standard anaesthesia care could be catastrophic. Our current system safeguards the public and should not be changed without due diligence.

IV. Consumer involvement

The ASA welcomes genuine consumer involvement and participation. The ASA recognizes the strong consumer input of the AMC. This should be transparent, accountable and qualitatively evidence based.

V. International medical graduates

The current system protects the public from inadequately trained healthcare workers. Bypassing the current system to meet the financial objectives of the government of the day by inappropriately facilitating the entry of healthcare workers trained to a lesser endpoint

could have a detrimental effect on public safety. Australia's quality universal healthcare system would be destabilised by the introduction of these recommendations.

VI. Funding

The suggested governance and funding arrangements would create an unnecessary and expensive, self-perpetuating level of bureaucracy whose costs would ultimately be borne by patients and students. This will drive out of pocket costs upwards for patients and lead to decreased access to care for the most vulnerable; rural, remote, Aboriginal and Torres Straight Islander people, the older and frail patients, those with chronic disease, mental illness and the poor.

Conclusion

In this report Professor Michael Woods has failed to make a case to change the current accreditation system performed by the AMC. The prime concern should always be about delivering safe, quality, equitable, sustainable and cost-effective healthcare. This will not be delivered by adopting change that is not evidence based and perpetuates expensive unnecessary bureaucracy. This draft report is driving a political agenda of unsubstantiated workforce reform and remains a threat to Australia's quality universal healthcare system.

References:

1. Australian Medical Council. About the AMC: Purpose and objectives. 2017. [Internet] available at: https://www.amc.org.au/about (accessed 14/10/17)
2. ANZCA. Our mission. 2017. [Internet] available at: http://www.anzca.edu.au/about-anzca/our-college (accessed 15/10/17)
3. Woods, M. Draft report: Independent review of the accreditation systems within the National Registration and Accreditation Scheme for health professionals. Australia's Health Ministers' Advisory Council September 2017
4. Productivity Commission Report Impacts of advances in medical technologies in Australia. (2005) [Internet] available at: https://ideas.repec.org/b/ris/prodcs/17.html (accessed 14/10/17)
5. Gladwell, M. Outliers: the Story of Success. 2008. Little, Brown and Company. USA

Yours sincerely,

Associate Professor David M. Scott
President, Australian Society of Anaesthetists