

RANZCOG Response to recommendations by the Productivity Commission

Introduction

The Productivity Commission Position Paper *Australia's Health Workforce* has articulated some major problems in health care delivery, in particular the fragmented approach to the healthcare workforce in Australia. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) welcomes the Position Paper and its intention to facilitate debate about the future of workforce in this country. Whilst RANZCOG supports a number of the recommendations, the College believes that there is also a number of questions and feedback that needs to be considered.

Skill mix and substitution

Ideally maternity services are provided by a team of professionals, comprising obstetricians, general practitioners and midwives, working cooperatively to ensure continuity of care for the woman during her pregnancy and following the birth of her baby, RANZCOG et al (2005a). This model utilises the workforce in the most efficient manner with midwives and/or general practitioners providing antenatal care and performing normal deliveries, with a robust triage system that ensures that at-risk women are referred in a timely manner to the specialist obstetrician.

RANZCOG considers that many of the suggestions for changes in service delivery are potentially effective innovations. For example, the emphasis on task delegation could offer alternative streams of service and could be very helpful in involving midwives in antenatal care in the private setting. This might also make it easier in the public setting for midwives to have responsibility for supervising normal labour and delivery with minimal medical input, providing that medical backup is close at hand. The caveat for this approach is that substitution may not create real or increased roles for non-doctors, but may result in service development/enhancement rather than labour substitution (Richardson, G et al. 1998). In order to free up doctors to do more complex work, substitution needs to consider patient through-put where care is restructured to reflect the supervision needs of staff.

If job substitution is to work, then job redesign will need to take place in many work settings. For example where, rural health organisations currently do not provide outpatient services within a hospital setting, public patients present to doctors' private rooms. A restructure of hospital services and funding arrangements would need to take place to make job substitution without degradation of service and outcomes possible.

Furthermore, by making a range of obstetric jobs attractive to midwives and GPs, the question of remuneration will arise. Will these health professionals be happy to carry out these tasks at the some level of pay, or will they be seeking pay rises in the future? Job substitution does not necessarily mean lower costs, and may in fact add considerably to health bill. Calpin-Davies (1999) suggests that a policy of doctor-nurse substitution assumes that there are sufficient nurses available for substitution, an assumption that may be false.

Another question raised by the job substitution proposal is the availability of midwives and GPs to perform this work. As with specialists, there is a shortage of midwives, especially in rural and regional areas. Will direct-entry midwives have all the associated skills required to perform competently in extended roles, where a good knowledge of medical, surgical and nursing is required? Is there a plan for midwives to be credentialed to a standard such as that set by NSW Department of Health (2005a)? If midwives are to prescribe, it follows that they must be trained in pharmacology to the same level as a nurse practitioner? (Victoria Department of Human Services 2005/ NSW Department of Health 2005b).

A further RANZCOG concern is that the importance of the generalist—be they specialist; GP or nurse—has not been sufficiently emphasized as being crucial to the delivery of rural health services. The Position Paper mentions the issue, but there seems to be more enthusiasm for training staff to be able to do specific tasks that might otherwise have been done by the generalist, lessening the work demands on that well qualified practitioner. The risk is that, instead of needing fewer staff in rural areas, more might actually be needed. For example, in the past the local GP would have diagnosed and managed a pregnant patient's diabetes, and given her dietary and lifestyle counseling. Now diabetes management is deemed to need a team—specialist, GP, nurse specialist, dietician, podiatrist etc. Rural health services are therefore seen as deficient if they can't access one or more of these individuals.

Substitution of health professionals has been suggested as a way in which some workforce shortages may be addressed, but RANZCOG is of the view that this may only postpone the problem.

Retention

Obstetrics, by its very nature is not a branch of medicine that can be practised only during office hours. In the past, solo private practice was the preferred model for a specialist obstetrician. Over time, solo private practice is being replaced by other practice models. For example, a group of specialists sharing rooms with on-call cover, and to a lesser extent group practices with shared responsibility for care are replacing solo private practice. These changes have largely resulted from increasing medico-legal pressure, a change in attitude to the importance of a balanced lifestyle and the feminisation of the speciality. Further pressure will come to bear as the push for 'safe hours' is increased. Already in many public hospitals and to a lesser extent private hospitals specialists are rostered to be on-site overnight in the delivery suite followed by a period of rest. This is in contrast to the practice of being on-call overnight and then retuning to work the next day without any, or sufficient time to rest and recover. Such a change requires a cultural shift. The 'safe hours' initiative has the potential to improve job satisfaction and retention or, conversely, may accelerate retirement for older specialists who are not satisfied with this less-continuous model of care. As with other proposed changes the impact must be monitored and evaluated to ensure that the resultant outcomes lead to improved quality and safety of care and retention of the workforce.

RANZCOG workforce surveys (2000 and 2003) have demonstrated that a significant number of specialists have either ceased obstetrics or planned to cease obstetrics in the next five years. The Commonwealth-funded Specialist Re-entry program has resulted in only one specialist taking up the opportunity to return to obstetrics. Once specialists have taken a decision to either cease obstetrics or wind down their practice they are very unlikely to reverse their decision.

A recent study revealed that the numbers of GPs who have now ceased carrying out obstetrics is significant. Robson et al (2005) demonstrate that once practitioners stop obstetrics for its unattractive lifestyle and low remuneration, they are unlikely to return. There are few incentives to coax most doctors back to covering obstetrics practice. The College notes that there are Commonwealth-funded retention schemes for rural GPs, whilst none exist for specialists. The proposed competitive remuneration, if introduced, should be extended to all rural health professionals and not only GPs. Indeed, the College reiterates its support for a higher MBS fee based on rural location as one means to attract and retain health service providers in these areas.

The introduction of stand-alone birthing units that are not supported by a specialist obstetric service has led to discord between some specialists and midwives. The RANZCOG position is that the safety of the woman and her baby is of paramount importance, and cannot support stand-alone birthing units that are not able to provide immediate emergency care (RANZCOG Statement 2005b). The unresolved tension surrounding this issue is impacting on the morale and job satisfaction of both specialist and midwives in the affected areas, and may well contribute to a further exodus from the profession.

One initiative that has the potential to support rural specialists and assist in recruitment and retention over time is the introduction of a specialist obstetric locum service (SOLS). The Commonwealth has funded a collaborative project between RANZCOG, Rural Doctor's Association and the Rural Doctor's Network to investigate the feasibility of establishing a funded obstetric locum service. The report is due in December 2005 and the College expects that a pilot project will be funded in 2006.

Protocol based care

In its initial submission to the Productivity Commission, RANZCOG offered comments on protocols and evidence-based practices (or lack thereof). The Position Paper has responded to these comments, but may have missed the point that RANZCOG was making. The RANZCOG position is that a reliance on protocols is no substitute for an experienced health professional. Protocols rely on the knowledge, training and adherence by individuals. If these are not audited, or measured against outcomes, then their effectiveness in ensuring patient safety and wellbeing cannot be determined. RANZCOG is concerned that health systems and organisations can use the availability of protocols to protect them from negligence claims, but do not necessarily provide the training and support for individuals to integrate the required knowledge and skills into everyday practice. Thus, RANZCOG acknowledges that protocols

are useful to guide practice but they can't replace clinical experience and expertise in provision of good health care.

Evaluation of care

It is essential that a consistent and inclusive data set is collected on all births throughout Australia with details of transfer between models of care.

Outcome measures should be regularly audited to ensure that the gains in maternity safety are maintained and not eroded.

Learning from others

The results of the New Zealand experience in obstetric/maternity services needs to be carefully evaluated in terms of (1) health outcomes and (2) impact on the workforce prior to implementation. It is important that changes that may impact adversely on the workforce or health outcomes are identified and addressed. For example RANZCOG workforce surveys have demonstrated that specialists are ceasing obstetrics for lifestyle and medico-legal reasons. Increased tension between specialists and midwives may hasten the departure of specialists and midwives from obstetrics in rural and urban settings.

Training

RANZCOG is cautious of 'competition' as a method of improving training – it is hoped that the Commission and others will take a full appraisal of the effect this has had on GP training before considering it for medical specialists. A full assessment of the cost effectiveness of competition, including the impact on outcomes, must be evaluated before committing to competition.

RANZCOG emphasizes that the real costs of training are hidden because of its reliance on pro bono activity. The College considers that this model of training may well be unsustainable in the future. The concept of 'funding following the trainee' is preferable to the existing situation in which training posts play a secondary role to service requirements. It would possibly be easier to get trainees into rural hospitals where limited budgets cannot usually accommodate trainees.

Accreditation

The Australian Medical Council (AMC) accreditation processes are working well. RANZCOG can see an expanded role for the AMC, which is well placed to assume the responsibility for accrediting the educational programs of health providers, training posts and hospital sites. RANZCOG suggests that an appropriately-resourced and restructured AMC might well serve as an 'umbrella' healthcare accreditation agency.

National Registration

RANZCOG strongly supports the Commission's proposal to improve the functioning of mutual recognition, in relation to the health workforce.

Workforce Planning

RANZCOG strongly supports the Commission's proposal to rationalize the existing workforce planning agencies into a single secretariat. This should

facilitate a coordinated approach to workforce issues and address the current fragmentation that occurs.

Conclusion and Recommendations

The following recommendations summarise the RANZCOG position on the proposals offered by the Productivity Commission Position Paper:

1. That strategies to support the recruitment and retention of all facets of the obstetric workforce be considered a high priority
2. That the Commonwealth funds the establishment of a Specialist Obstetric Locum Service to support the rural obstetric workforce
3. That national registration of doctors be introduced as a priority to facilitate more flexible movement of the medical workforce across state boundaries
4. That workforce planning be coordinated to consider all health workforce areas, rather than addressing the medical work force in isolation
5. That workforce planning is addressed as a matter of urgency, and supported by comprehensive health outcome data collection and evaluation
6. That a consistent approach to the assessment of overseas trained specialists (OTS) and area of need practitioners (AoN) be mandated, Australia wide
7. That one medically-led agency is responsible for accrediting all health disciplines
8. That the training and education of healthcare providers be reformed and re-designed to focus on education and development rather than service delivery

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