



National Health &  
Hospitals Reform  
Commission

**Submission**

Australasian College of  
Podiatric Surgeons

**ACPS Council  
May 2008**



National Health & Hospitals Reform Commission

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Dear Commissioners

**RE: NHHRC Call for Submissions**



On behalf of the Australasian College of Podiatric Surgeons (ACPS), I have pleasure in making this submission to the National Health & Hospitals Reform Commission during its consultative process with the community and health providers.

The ACPS represents the interests of Australian podiatric surgeons, and is the peak body for the training and accreditation of podiatrists in the specialty of podiatric surgery.

We are grateful for the opportunity to provide the Commission with a submission which outlines our views on the importance of health reform, and the contribution that podiatric surgery can make to the future health of our nation.

Additionally, we would like to inform the commissioners that a report examining the potential economic impacts of greater utilisation of podiatric surgeons in the Australian Health care sector is currently under preparation by *Access Economics*. This report is expected to be released in mid July. As soon as this report is available the ACPS will forward the commission a copy

We look forward to the outcome of your review, and working with you in the future for the better health of Australians.

Sincerely

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*“Podiatric surgeons represent an example of an existing non-medical health profession struggling to grow and develop under a range of legislative, political and logistical barriers.”*

## I. Executive Summary

The draft principles which have been identified by the NHHRC summarize effectively the range of issues facing the health system. These principles are relevant to all stakeholders in health, for importantly it is often the restrictions and barriers placed on health providers which prevent successful achievement of the philosophies that such principles espouse.

The example of podiatric surgery can be used to effectively illustrate many of the areas requiring reform. Indeed pursuing reform to address these issues provides an opportunity for a controlled and monitored test case. Increased utilisation of podiatric surgeons has been proposed by many authors, including the Productivity Commission <sup>1,3,4 9,27,20</sup>.

The ACPS recognises the need for broad based health workforce reform, and the example of restrictions placed on the activities of podiatric surgeons will be a practical illustration used in our discussion of the draft principles of the NHHRC.

The recent Productivity Commission paper “*Australia’s Health Workforce*”, provided governments and the community with a range of recommendations for more efficient utilisation of health professionals in Australia. In an era of drastic health workforce shortages and expanding elective surgery waiting lists, it is time that more of these recommendations were effectively implemented. Podiatric surgeons represent an example of an existing workforce with skills which can contribute to the current issues facing the health system. Appropriate reform will see this workforce expand to meet the increasing need within the community.

In Australia there are a wide range of health professions, such as podiatric surgeons, who are given limited opportunity to provide an effective contribution to health care. Such limitations are widely accepted as the result of historical role delineation which restrict the use of modern therapeutics, drugs and surgery to well established professional silos <sup>11,14</sup>. Other non-medical health professions (such as optometrists, physiotherapists, nurses and radiographers) are also stifled by the lack of opportunity and support for higher productivity <sup>1,6,7,8</sup>.

The argument to simply ‘train more doctors’ cannot be promoted as the main solution to our health workforce crisis. Doing more with what already exists, and increasing the productivity of the existing broader health workforce should play a prominent role.

Podiatric surgeons are an example of a non-medical health profession under pressure from a range of legislative, political and

## Summary NHHRC

### Recommendations

1. Allow rebates to apply for relevant surgical services in the Medicare Benefits Schedule when performed by podiatric surgeons, to provide equity, choice and flexibility for health consumers
2. Allow podiatric surgeons to directly refer to medical specialists, without the need for a GP consultation, in order to improve clinical safety and efficiency
3. Provide targeted funding for health departments to employ podiatric surgeons to contribute to public elective surgery waiting lists in a cost-effective manner
4. Provide postgraduate training opportunities for podiatric surgeons in public hospitals, in order to develop and integrate the workforce with existing models of care.
5. Encourage research investment into examining the future innovative roles that podiatrists and podiatric surgeons can play in providing traditional medical services.
6. Encourage harmonisation of legislation for podiatric drug prescribing across all states and territories, and PBS funding comparable to medical prescriptions.

logistical barriers. The lack of access to Medicare rebates, barriers to referring directly to relevant medical specialists, and lack of public podiatric surgery services are prime examples of logistical barriers that affect the productivity of our members in the health system. These barriers also create distinct access issues for the public and reinforce the marginalisation of podiatric surgeons and our patients. This potentially is detrimental to effective health outcomes.

Despite these obstacles, podiatric surgeons have proudly provided over 30 years of quality elective reconstructive foot and ankle surgical services to Australians, almost entirely from within the private sector.

Overseas examples abound as to the important role that podiatrists play in independent health service provision – from drug prescribing, to surgical triage, and the types of specialist interventional surgical services that Fellows of the ACPS already provide. This is reflected in countries such as the United Kingdom and the USA, where podiatrists and podiatric surgeons provide a much broader range of integrated health services in both the private and public sector<sup>14,18,23</sup>.

The role of podiatric surgeons has been effectively constrained by lack of funded and integrated training of podiatric surgeons and lack of Medicare rebates for the services of podiatric surgeons. Within the current structure for the health and education system podiatrists must enter self-funded, lengthy training programs and have limited work opportunity when qualified in foot surgery. Podiatrists then have to consider completing an additional medical degree to access training, funding and work opportunities. This is an inefficient, costly and unnecessary option based upon outcomes research in Australia and overseas. True integrated training and shared care arrangements will produce cost effective safety and quality in health care.

Similar issues exist in many health professions and the Commission should consider recommending that barriers to existing workforces are removed and that the health education sector is remodelled to allow effective integration of the non-medical workforce into expanded roles.

The summary recommendations of the ACPS ([Box Left](#)) highlight in a profession-specific manner the changes which are required to more effectively utilise the existing and future podiatric surgery workforce. It is these measures, in combination with reform in the education sector, which will ultimately address the principles in health care that the Commission seeks to address.

## Current training pathway to become a podiatric surgeon

*Undergraduate podiatry degree (4 years)*

*2 years clinical experience*

*Master's degree in Podiatry (2 years)*

*Fellowship training (3-5 years)*

*Final examinations in practical and theoretical knowledge*

## 2. Introduction

Podiatric surgeons are a specialist group of the podiatry profession, providing invasive surgical care for both common and complex foot and ankle conditions that are unresponsive to conservative care. Like dental surgeons, they are independent health practitioners, and likewise the training of a podiatric surgeon involves significant volumes of undergraduate and postgraduate medical studies.

As primary care providers, podiatrists and podiatric surgeons are able to be accessed by members of the public without the need for medical practitioner referral. They offer services which are complementary to decentralised forms of health care provision, via shared care and delegation, and are well placed to facilitate local autonomy for health consumers and other existing health service providers.

The pathway to becoming a podiatric surgeon relies on base undergraduate degree in podiatry. This is supplemented with a postgraduate Master's degree and practical Fellowship surgical training (see box at left).

Podiatric surgeons provide surgical treatment for a range of common lower extremity conditions, including;

- *Nerve entrapments*
- *Arthritic joint conditions (eg osteoarthritis, rheumatoid arthritis)*
- *Foot deformities (eg bunions, hammertoes)*
- *Tendon problems (eg ruptures, degeneration)*
- *Skin lesions*
- *Tumour excisions*
- *Fracture management*
- *Amputations*
- *Chronic foot ulcerations and infection (eg secondary to diabetes)*

Podiatric surgeons are recognised under various pieces of Commonwealth and State legislation, and the conduct and performance of podiatric surgeons is monitored by both the ACPS and State/Territory Podiatrists Registration Boards. Podiatric surgeons can prescribe restricted or controlled drugs related to surgery in some States according to local drugs and poisons legislation, however there is no uniform legislation and considerable variation between jurisdictions.

*Barriers to the growth of Podiatric Surgery*

There are many and varied impediments to the growth and increased utilisation of podiatric surgeons, and enhanced scope activities by other non-medical health professions in Australia. A fundamental issue that has caused this has been that historically, non-medical professions have been either surreptitiously, or accidentally, 'left out' of key policy and legislative instruments that facilitate the clinical and administrative duties of health professionals<sup>11</sup>.

The long known sociological phenomenon of 'medical dominance' over 'subordinate' health professions continues to prevail in the Australian health system and prevents us from joining the likes of the USA and UK, where professions such as podiatry provide a much broader scope of practice and higher level of integration within public health facilities<sup>4,11,18</sup>.

Because of this, the medical profession in Australia has enjoyed an almost exclusive monopoly with regard to;

1. *Private clinical services funding (eg Medicare)*
2. *Research funding (eg through the priorities of the NHMRC)*
3. *Logistical support funding (eg Divisions of General Practice)*
4. *Undergraduate funding (eg higher HES payments to universities for medical degrees versus allied health degrees)*
5. *Postgraduate training (eg funded public hospital registrar appointments and specialist training programs)*
6. *Unrestricted access to innovations in diagnostics, therapeutics and new technologies*

Due to these obstacles, and many others, non-medical health professions in Australia such as podiatry, have been unable to grow, mature and make a significant impact on the public health of society. In essence, they have effectively been 'shut out' of providing many clinical services because of access restrictions to modern drugs and therapeutics, diagnostic technology, lack of access to Medicare rebates for patients or public positions, or receiving funding to provide 'evidence' of the efficacy of their services.

Where incremental advances in scope of practice have been achieved, this has been against the resistance of the various political arms of the medical profession, and against a general malaise from governments to address the monopolistic status quo in health care provision.

The dominant stakeholder in the supply of education and training for surgical services in Australia is the Royal Australasian College of Surgeons (RACS), who have a long and honoured history within this country. However, they have increasingly been the subject of criticism from governments and the ACCC regarding

the alleged restriction of supply of new surgeons to the community <sup>29</sup>.

RACS have indicated that they have qualified support for task transfer in the practice of surgery, but specifically under the 'supervision' of their members <sup>2</sup>. However, despite attempts from the ACPS to commence a dialogue with RACS to implement a broader role for podiatric surgeons within health care teams, their position to date could only be described as adversarial, at best.

### 3. Comments on NHHRC Draft Principles

#### 1. People and family centred:

*The direction of our health system and the provision of health services must be shaped around the health needs of individuals, their families and communities. The health system should be responsive to individual differences, cultural diversity and preferences through choice in health care. Pathways of care, currently often complex and confusing, should be easy to navigate and, where necessary, people should be given help to navigate the system including through reliable and evidence based information and advice to make appropriate choices. Care should be provided in the most favourable environment: closer to home if possible and with a preference for less 'institutional' settings and with an emphasis on supporting people to achieve their maximum health potential.*

The ACPS believes strongly that health consumers should be empowered with the opportunity to make their own health care choices, based on their personal preferences, and with quality information to guide their decisions.

At the moment, however, individuals and families who choose their preferred health provider are adversely affected, either due to decision making preferences on the part of 'gate-keepers' in the health system, or financial penalties if they choose a health professional that does not satisfy the requirements for Medicare rebates.

The changing demographics of our nation mean that there will need to be an increased emphasis on the care of older Australians. Philosophically, the podiatry profession considers that its role for this group of the population is to aid and enhance mobility and independence, which in turn facilitates exercise and positive general health outcomes.

#### 2. Equity:

*Health care in Australia should be accessible to all based on health needs not ability to pay. The multiple dimensions of inequality should be addressed, whether related to geographic location, socio-economic status, language, culture or indigenous status. A key underpinning for equity is the principle of universality as expressed in the design of Medicare, the Pharmaceutical Benefits Scheme and public hospital care. Addressing inequality in health access and outcomes requires action beyond these three programs, including through engagement with other policy sectors (such as the education system, and employment). The health system must recognise and respond to those with special needs (the marginalised or underprovided for groups in society). Special attention needs to be given to working with Aboriginal and Torres Strait Islander people to close the gap between indigenous health status and that of other Australians.*

The ACPS feels a strong obligation to provide surgical consultations and services to all sectors of the community, including those with special needs or groups with socioeconomic, cultural or location barriers.

However, there is simply no opportunity for our members to participate in broad public health care due to existing policies which exclude podiatric surgeons from public funded surgical services. This is in direct contrast to international experiences.

Equity in the design of Medicare, the PBS and public hospital services is a principle held strongly by all Australians. However, these systems and their governance are a product of earlier decades, and have not been flexible in adapting to changes in community expectations, increased knowledge and workforce expertise, and shifting patterns in health service delivery.

The ACPS, like the Productivity Commission and others, feel that utilising existing podiatric surgeons (and training others) would help reduce orthopaedic waiting lists as they relate to foot and ankle surgery.<sup>1,4,9</sup> There is little doubt of the community demand that remains unmet in elective surgery, highlighted by the requirements by states and the Commonwealth for additional funding for these services. However, seeking greater productivity from our surgical services, rather than ever-increasing funding, should form part of the solution to elective surgery waiting lists.

At a regional level, podiatrists with expanded skill sets in surgery or prescribing provide a more locally based, decentralised range of services, without the need for duplication and 'double-handling' by medical practitioners. The purchasing of podiatric surgery services in local NHS Trusts within the United Kingdom is a prime example of this decentralised approach to health care<sup>10,14</sup>.

In the private sector, health consumers currently face a choice in foot and ankle surgery providers in Australia. This is principally between podiatric surgeons and orthopaedic surgeons. However, there is a significant financial disadvantage to health consumers if their preference is for a podiatric surgeon. Medicare rebates do not apply for the podiatric surgeons' or anaesthetists' fees, and only a base rate of cover exists for the hospital charges if private health insurance is used. The consumer is consequently left with large out of pocket expenses for any given procedure, simply because a podiatric surgeon is supplying the service.

In the public sector, no choice exists at all as podiatric surgeons are not employed in the public sector and orthopaedic surgeons perform the majority of all foot and ankle procedures. More importantly, this lack of choice comes with an economic penalty to taxpayers, as there is growing evidence that podiatric surgeons provide a cost effective service in foot surgery to public health systems, compared to traditional providers<sup>14,21</sup>.

However, individuals and interest groups opposed to podiatric surgeons argue that the role of the podiatrist should be restricted to non-surgical care, and utilise the term 'Podiatric Technician' as an a means of describing and demeaning the podiatry profession<sup>26, 27, 28</sup>. The ACPS believes these hostile attitudes are examples of the anticompetitive nature of the medical profession towards jealously guarding its monopolistic position on the hierarchical ladder of the health care system.

*“The most effective way in which this could occur would be for funding to be provided to emulate the Visiting Optometrists Scheme - which was designed to provide outreach services to remote communities who lack access to primary eye care. A podiatric version of this scheme, incorporating podiatrists and podiatric surgeons could make a substantial impact on Indigenous health.”*

There is room for the federal and state governments to ensure that appropriate reforms are put in place to facilitate the development of podiatric surgery as an integral part of the Australian healthcare sector. Reform should be directed at ensuring improving access of podiatric surgeons to both private and public facilities which provide acute care (surgical services). Establishment of podiatric surgical units in public hospitals with training programs is essential to foster the development of podiatric surgery.

Rural and remote health service delivery provides a strong case for shifting the boundaries of traditional service delivery. The absence of generalist or specialist medical professionals plagues many country communities <sup>5</sup>. The response by governments to date has been to attempt to bond new medical graduates to these locations, or fill vacancies with overseas trained doctors (OTDs). This has been, with some exceptions, and unsuccessful or expensive approach.

Instead of an inordinate reliance on medical health professionals for services, rural and remote communities would benefit greatly by allowing a far wider role for existing health providers. As discussed by the Productivity Commission<sup>1</sup>, radiographers can provider x-ray reporting, nurse practitioners can deliver primary care services, and podiatrists and podiatric surgeons can provider broader medical and surgical foot care, especially for the lower extremity complications of diabetes. However, respecting the expertise of these professions should be reflected in independent (team oriented) practice, not supervised or delegated under the direction of a medical practitioner.

There are very few podiatrists employed in rural and remote areas of Australia, where Indigenous populations have the greatest health problems and least access to health services. Despite this, podiatrists have a long history of outreach work to these communities, and a demonstrated and real commitment to improving outcomes.

The most significant area of need that podiatrists can address for Indigenous Australians is in the prevention of amputation through the appropriate management of diabetic foot complications. Specialised wound care, pressure offloading devices and diagnostic assessments are vital to prevent amputations due to diabetes, but are almost non-existent in most remote Indigenous communities.

Attracting metropolitan-based podiatrists and podiatric surgeons with expertise in the care of diabetic foot complications needs to occur to deal with these preventable problems. The most effective way in which this could occur would be for funding to be provided to emulate the *Visiting Optometrists Scheme* - which was designed to provide outreach services to remote communities who lack access to primary eye care. A podiatric version of this scheme, incorporating podiatrists and podiatric surgeons could make a substantial impact on Indigenous health.

### 3. Shared responsibility:

*All Australians share responsibility for our health and the success of the health system. We each make choices about our life-style and personal risk behaviours, shaped by our physical and social circumstances, life opportunities and environment, which impact our health risks and outcomes. As a community we fund the health system. As consumers or patients we make decisions about how we will use the health system and work with the professionals who care for us. Health professionals have a responsibility to communicate clearly, to help us understand the choices available to us, and to empower us to take an active role in our treatment in a relationship of mutual respect. The health system can only work effectively if everyone participates according to these shared responsibilities, recognising and valuing the important roles of both consumers/patients and health staff. The health system has a particularly important role in helping people of all ages become more self reliant and better able to manage their own health care needs. This includes helping people to make informed decisions through access to health information and by providing support and opportunities to make healthy choices; and by providing assistance for managing complex health needs.*

Systems should be put in place that encourage an improved understanding of the relative roles of health care practitioners and communication between the different health care practitioners. Shared responsibility also means shared care, however effective shared care means integration and communication. Our current system encourages fragmentation and isolation, because free referral between specialised providers is discouraged or penalised. Less than optimal outcomes can result from this approach.

Involvement and access issues around e-health initiatives also need to include non-medical providers so that information about patients is freely available to those involved in shared care arrangements. This is particularly pertinent when dealing with patients who require surgery, where a lack of detailed information and medical history can adversely affect outcomes.

### 4. Strengthening prevention and wellness:

*We need a comprehensive and holistic approach to how we organise and fund our health services and work towards improving the health status of all Australians. The balance of our health system needs to be reoriented. Our health system must continue to provide access to appropriate acute and emergency services to meet the needs of people when they are sick. Balancing this fundamental purpose, our health system also needs greater emphasis on helping people stay healthy through stronger investment in wellness, prevention and early detection and appropriate intervention to maintain people in as optimal health as possible. Recognising the diverse influences on health status, our health system should create broad partnerships and opportunities for action by the government, non-government and private sectors; balance the vital role of diagnosis and treatment with action and incentives to maintain wellness; create supportive environments and policies, protect our health and prevent disease and injury in order to maximise each individual's health potential.*

Though podiatric surgeons often focus on a tertiary management role for many foot and ankle conditions, there cannot be any doubt that a preventative approach to many health problems can decrease the reliance on surgical care.

An apt example is the prevention of foot complications from diabetes; where global health management issues (including weight and exercise management, healthy eating, and smoking cessation) will greatly decrease the burden of foot and or leg amputations.

However, it is widely accepted that the involvement of podiatrists in diabetes care allows for the early detection and intervention of foot complications, and reduces the likelihood of amputation.

Many broader aspects of health and lifestyle choices have the ability to lessen the burden of foot pathology on our health system.

It is important to consider that investment in podiatrists and podiatric surgeons allows health consumers to maintain mobility and independence until later in life, and plays a vital role in maintaining general health and the ability for exercise.

## 5. **Comprehensive:**

*People have a multiplicity of different health needs which change over their life course. Meeting those needs requires a system built on a foundation of strong primary health care services, with timely access to acute and emergency services.*

Health consumers require a comprehensive approach to the care of any given condition. The ACPS believes that non-medical health professions can play a much greater role in comprehensive primary and acute care services than is currently the case.

A more effective approach to the use of allied health practitioners, through 'task transfer' principles, reduces the burden on primary health care providers (GP's) providing more timely, efficient access to health care.

Podiatrists and podiatric surgeons alike specialise only in foot and lower extremity complaints, and provide highly effective, evidence-based interventions – from babies (eg club foot), through to the elderly (eg falls prevention and mobility enhancement). However, they are drastically underutilised.

Examples of clinical activities that podiatrists and podiatric surgeons could play a greater role include;

- *Triage of foot and lower extremity complaints in public outpatient departments (eg orthopaedics, rheumatology, endocrinology)*
- *Emergency management of acute foot and ankle injury (eg fractures, soft tissue trauma)*
- *Drug prescribing for common pedal conditions (eg infection, arthritis, acute pain management)*
- *Surgical care of acute and chronic foot and lower extremity complaints*

Many lower extremity complaints require timely referral for pathology and radiology investigations. Currently though, the majority of these investigations need to be referred via a GP for a patient to receive Medicare rebates and minimise out-of-pocket expenses. To allow a patient to claim a Medicare rebate, podiatrists can only refer for plain x-ray and ultrasound investigations.

*“Common, well-proven medications (such as antibiotics, analgesics, antifungals etc) are essential for treating the complaints that podiatrists and podiatric surgeons manage.”*

*“Nationally, and internationally, there has been considerable evidence that podiatric surgeons provide safe and cost effective foot and ankle surgery in the public sector, even when compared to equivalent providers.”*

This adds delays and additional costs to the management of these conditions when a blood test or a CT scan might be necessary.

Common, well-proven medications (such as antibiotics, analgesics, antifungals etc) are essential for treating the complaints that podiatrists and podiatric surgeons manage. Though there are some jurisdictions that allow a small amount of podiatry prescribing, the majority of patients have to again access a GP to receive cover under the Pharmaceutical Benefits Scheme. Where prescribing is allowed, it is only for a very narrow range of medications.

However, there is no health service or health workforce planning with respect to podiatric surgeons. Podiatric surgeons are a small profession and are simply overlooked even though the federal government’s legislation recognizes podiatric surgeons in terms of ‘professional attention’ along with medical practitioners, dentists and midwives [Health Legislation Amendment (Podiatric Surgery and Other Matters, 2004) Act.].

#### **6. Value for money:**

*The resources available to support our health care system are finite, and the system must be run as efficiently as possible and be positioned to respond to future challenges. Delivering value for money will require appropriate local flexibility in financing, staffing and infrastructure. The health system should deliver appropriate, timely and effective care in line with the best available evidence, aiming at the highest possible quality. Information relating to the best available health evidence should be easily available to professionals and patients. Introduction of new technology should be driven by evidence and cost-effectiveness. Pathways to care should be seamless with continuity of care maximised, with systems in place to ensure a smooth transfer of information at each step of the care pathway, making effective use of information technology.*

The use of podiatric surgeons for elective foot and ankle surgery represents an opportunity of cost savings for the health system, compared to traditional providers.

Nationally, and internationally, there has been considerable evidence that podiatric surgeons provide safe and cost effective foot and ankle surgery in the public sector, even when compared to equivalent providers <sup>10, 12, 13, 17, 20, 23, 30</sup>. In the United Kingdom National Health Service (NHS), podiatric surgeons have often been chosen in preference to traditional orthopaedic services in many Community Trusts to provide foot surgery services <sup>10, 12</sup>. The NHS recognises that podiatric surgeons provide more cost effective care, through the use of a greater range of day surgery procedures principally under local anaesthesia. However, the Australian health system has failed to implement such approaches, despite repeated attempts by the ACPS to raise the issue with governments.

In the USA, podiatrists have been shown to undertake the majority of elective foot surgery procedures, and at a lower cost when compared to orthopaedic surgeons <sup>30</sup>.

Podiatric surgeons well recognise the issue of cost-effective interventions, particularly since consumers of our services frequently face considerable out of pocket costs on private services.

Shared care arrangements exist in many areas of health care, from diabetes to obstetric services. Podiatrists in the community and tertiary hospital facilities are frequently engaged in team-oriented practice for the care of chronic conditions such as diabetes and arthritis. However, there is a much greater contribution that the profession can make in these arrangements, and even more so if podiatric surgeons were also utilised.

## 7. Providing for future generations:

*We live in a dynamic environment and changing populations. Health needs are changing with improved life expectancy, community expectations rising, advances in health technologies, an exploding information revolution and developments in clinical practice. There are new avenues and opportunities for how we organize and provide necessary health care to individuals, using the health workforce and technologies in innovative and flexible ways. Health professionals need to be able to adapt to future health needs. The education and training of health professionals across the education continuum are a responsibility of the whole health community in partnership with the education sector. Continuing education ensures that health professionals are prepared to meet these changing needs. The important responsibility of the health care system in teaching, training future generations of health professionals for a changing health care sector and roles, participating in research and in creating new knowledge for use in Australia and throughout the world should be actively acknowledged and resourced appropriately as an integral activity. The health sector's commitment to education and research, and its relationship with the education and training sector, should be planned and implemented in a logical and seamless way involving all relevant sectors: public and private, institutional and community.*

The ACPS agrees with this draft principle entirely, particularly aspects related to “using the health workforce and technologies in innovative and flexible ways”, and “training future generations of health professionals for a changing health sector and roles...”.

Lack of funding for university and clinical education in public hospitals has meant that the ACPS is currently the sole provider of training and education for podiatrists in the specialist field of podiatric surgery. Hence, we intrinsically appreciate and respond to the need for using our health workforce in wider and more flexible ways.

Currently, Commonwealth support for higher education places in Australian tertiary facilities places podiatry in Item 4 of the funding cluster arrangements under the *Higher Education Support Act 2003*, with other allied health professions, and courses such as foreign languages and performing arts. This funding cluster attracts less than two-thirds of the Commonwealth support that degrees in medicine, dentistry or veterinary sciences receive. However, podiatry is a clinically intensive course of study, with high costs related to clinical infrastructure to deliver student exposure to medical, surgical, biomechanical and pharmacology subjects. It is in no way dissimilar to the training of undergraduate dentists and medical practitioners, which are practical courses producing graduates with a technical skillset.

An objective assessment of the costs in education and training for podiatry students should be performed in order for these degrees to be funded at a similar level to medicine and dentistry.

Training future generations of health professionals, particularly for specialised roles in the postgraduate setting requires access to public sector training facilities and funding. For the past 30 years, College Fellows have self funded their postgraduate training in the private sector, and this has been the greatest factor limiting the growth of our workforce. Podiatric surgeons must be allowed to participate in surgical training in public sector institutions in order to become integrated into the broader health workforce framework, and reduce the economic burden on trainees. Public sector registrar training posts facilitate research opportunities, and improve the scope of surgical and medical exposure leading to better quality practitioners.

Career pathways are limited for non-medical professionals in the public sector. Whereas medical practitioners can have postgraduate training and study rewarded in consultant positions with significant status and remuneration, the only opportunities for non-medical professionals to seek better remuneration is through a change to a non-clinical/administrative role. This results in the best and most experienced clinicians leaving a caring role for a managerial position.

In 2004, the UK NHS 'Agenda for Change' reforms provided the non-medical professions with an opportunity for the first time to achieve roles within the health system that had previously been restricted to the medical profession. Consequently, in the NHS podiatric surgeons are typically employed as 'consultant' grade practitioners due to the substantial postgraduate experience and training they have accrued.

<b>2 NHS Career Framework</b>	
<b>Level</b>	<b>Role</b>
9	More senior staff
8	Consultant practitioners
7	Advanced practitioners
6	Senior practitioners/Specialist practitioners
5	Practitioners
4	Assistant practitioners/Associate practitioners
3	Senior health care assistants/technicians
2	Support workers
1	Initial entry level jobs

(source: Brooks P, Robinson L, Ellis N. Options for expanding the health workforce. *Australian Health Review* 2008 32 (1): 156-60)

The ACPS believes that the Australian health system would benefit enormously from adopting a similar approach to the employment of health professionals in terms of recruitment, retention, productivity and job satisfaction.

The barriers and systematic constraints in favour of one particular profession give rise to inefficient markets by muting price signals, distorting patterns of health service consumption and constrain workforce substitution.

Training future generations of podiatrists and podiatric surgeons needs to occur with a greater emphasis of integration with public training hospitals. Currently podiatric surgeons need to self-fund their training almost exclusively in the private sector, and need to travel to the US and UK to experience how podiatric surgery services occur in public health facilities. There is no doubt that with podiatric surgeons training alongside other health care providers in Australian public hospitals, that many of myths and distorted perceptions from other groups will be resolved.

We suggest that the experience of podiatric surgeons in the health system highlights that a more competitive health market can be achieved by removing those impediments to the health market that have historically functioned to restrict competition and protect closed-shops.

## **8. Recognise broader environmental influences shape our health:**

*Our environment plays an important role in affecting our health and in helping us to make sensible decisions about our health. The environment here is taken to mean the global climate, the physical and built environment (air quality, the workplace, planning decisions which affect our health) and the socio-economic environment (people in the workforce generally have better health than the unemployed, better educated people have better health and have responded better to health campaigns and tend to smoke less). Peers and family shape both our health (and development of our children) and our adoption of healthy lifestyles. The health system of the future needs to work at these multiple levels to promote health with many and varying agencies and partnerships. These partnerships must be effective and with players outside the health system, whether they be transport departments, local councils, employers, business and worker organisations, and schools and universities.*

The Australian podiatry profession, and the ACPS, are active participants in many community and industry partnerships to improve the outcomes of foot care for our citizens, as well as those in countries less fortunate than ours via surgical charity missions. As such the tenants espoused in the above principles are supported by the ACPS.

## **Governance principles**

### **9. Taking the long term view:**

*A critical function for effective governance of the health system is that it acts strategically: that short-termism and the pressure of the acute does not crowd out attention and planning for the long term. A responsible forward-looking approach demands that we actively monitor and plan the health system of the future to respond to changing demographics and health needs, clinical practices and societal influences. This requires capacity to seek input from the*

*community and those within the health sector (providers and managers), to assess evidence and develop and implement plans to improve health and health care.*

The experience of most front-line health professionals is that there is little forward planning in our health system, and even less that directly involves the non-medical workforce.

Like our tax system, there has been continuous 'tinkering' with the edges of the health system, when significant and far-reaching reform is needed to redefine roles and responsibilities within the sector.

The weight of input from dominant players in the market frequently drowns out the voices of smaller organisations such as the ACPS, who fight for greater reform and equity in health care service delivery. The status quo benefits key stakeholders who have grown accustomed to being the beneficiaries of substantial public funding over generations.

As stated previously, podiatric surgery is a prime example of an emerging service in the Australian health environment, and the health system of the future must recognise new clinical practices with suitable evidence for efficacy and safety.

#### **10. Safety and quality:**

*There should be effective systems of clinical governance at all levels of the health system, to ensure we learn from mistakes and to improve the safety and quality of services. The first step in ensuring effective clinical governance is that there is a culture that embraces improvement in patient safety and quality. This includes an emphasis on open, transparent reporting. There must be a just and positive culture in dealing with adverse events, mistakes and near misses. All of this requires the development of effective organisational systems that promote safety and quality, including appropriate systems of open disclosure and public accountability for the whole system.*

The ACPS is proactive in providing reassurance to the community regarding the safety and quality of its members activities.

Podiatric surgeons, collectively and individually, are accountable for the clinical services they are trained to provide. Though some stakeholders perceive that the medical profession is best-placed to hold a position of ultimate authority and responsibility for patient care, other health professions are equally capable in this respect, and have demonstrated so for many decades.

The ACPS supports the notion of transparency with respect to the quality and performance of its members, and would also support reporting that was made available to consumers and health departments regarding the outcomes of individual providers.

*“The ACPS has been an active participant with the Australian Commission on Safety & Quality in Health Care, and supports the recommendations of this Final Report on the Review of National Safety and Quality Accreditation Standards.”*

Despite misleading comments to the contrary <sup>28</sup>, the ACPS has implemented an ongoing audit and accreditation program, which will evolve and improve as national health policy is finalised in this area. We recognise that adverse events and complications can and do occur, but the process for dealing with these issues should involve a process of reflective learning and not simply punitive measures.

A lessening of the practice of ‘defensive medicine’ as a means of dealing with growing litigation from dissatisfied consumers, can also bring better transparency and open disclosure when adverse outcomes occur. Tort reform must be considered here.

The ACPS has been an active participant with the *Australian Commission on Safety & Quality in Health Care*, and supports the recommendations of this Final Report on the Review of National Safety and Quality Accreditation Standards.

### **11. Transparency and accountability:**

*The decisions governments, other funders and providers make in managing our health care system should become clearer and more transparent. Funding should be transparent. The responsibilities of the Commonwealth and state governments and the private and non-government sectors should all be clearly delineated so when expectations are not met, it is clear where accountability falls. Accountability extends to individual health services and health professionals. Australians are entitled to regular reports on the status, quality and performance of our whole health care system, both public and private, ranging across the spectrum from primary to tertiary care and at local, state and national levels.*

The ACPS supports transparency and accountability in health funding arrangements, particularly in the context of contemporary competition policy.

This transparency should apply to non-government organisations, in particular health insurance companies, who appear reticent to provide significant levels of funding to general and surgical podiatric services, despite their statutory obligations.

### **12. Public voice:**

*Public participation is important to ensuring a viable, responsive and effective health care system. Participation can and should occur at multiple levels, reflecting the different roles that individuals play at different times in their lives. This includes participation as a ‘patient’ or family member in using health care services, participation as a citizen and community member in shaping decisions about the organisation of health services, and participation as a taxpayer, voter, and in some cases shareholder, in holding governments and corporations accountable for improving the health system.*

The ACPS agrees with this principle in its entirety.

### **13. A respectful, ethical system:**

*Our health care system must apply the highest ethical standards, and must recognize the worth and dignity of the whole person including their biological, emotional, physical, psychological, cultural, social and spiritual needs. A significant focus must include respect and valuing of the health workforce. Those working within the health sector must be aware of ethical considerations throughout their training and in their daily clinical practice.*

The ACPS agrees with this principle in its entirety.

#### 14. **Responsible spending on health:**

*Good management should ensure that resources flow effectively to the front line of care, with accountability requirements efficiently implemented and red tape and wastage minimised. Funding mechanisms should reward best practice models of care, rather than models of care being inappropriately driven by funding mechanisms. Funding systems should be designed to promote continuity of care with common eligibility and access requirements to avoid program silos or 'cracks' in the health system. There should be a balanced and effective use of both public and private resources. New technologies should be evaluated in a timely manner, and where shown to be cost effective, should be implemented promptly and equitably. Information and communication technologies, in particular, should be harnessed to improve access in rural and remote areas on a cost effective basis, to support and extend the capacity of all health professionals to provide high quality care.*

Responsible spending on health is crucial when the economy is faced with a growth in health expenditure outstripping almost all other sectors of the economy.

New paradigms of cost-effective service delivery must be considered and implemented, and podiatric surgery is a perfect example of this. Podiatric surgeons have a demonstrated history of care for common surgical disorders of the foot and ankle in Australia, yet no podiatric surgeons are employed in our public hospitals. Historical attempts (internationally) to compare the economic data for podiatric and orthopaedic surgeons has shown that podiatrists have provided less expensive services, with a greater number of procedures provided for a particular condition, and at significantly shorter hospital length of stay<sup>30</sup>.

We seek an opportunity to demonstrate that we can provide best practice in foot and ankle surgery with comparable or reduced costs to the health system. Current systems of data collection prevent such modelling and research activity.

#### 15. **A culture of reflective improvement and innovation:**

*Reform, improvement and innovation are continuous processes and not fixed term activities. The Australian health system should foster innovation, research and sharing of practices shown to be effective and to improve not only the specific services it provides, but also the health of all Australians. Audit, quality feedback loops and 'Plan, Do, Study, Act' cycles, supported by information and communication technologies, can enable and drive this. The continuum of basic science, to clinical and health services research will underpin this and needs to be embedded.*

Being a professional requires a commitment to life-long learning and assessing evidence of better ways of providing services. Accreditation, compulsory continuing education and other techniques are already used by the ACPS to ensure its members stay abreast of contemporary best practice.

Currently, the 'silo' approach to health care places patients into situations where they cannot move freely between health care providers that might assist their given complaint. This begins at the time of undergraduate clinical education, where health professionals often enter into a course that often provides little interaction with other health professionals. It may not be until the graduate enters a hospital setting that they meet other health care providers for the first time, and learn something of each others relative roles and contributions within the health system.

For professions such as podiatry and podiatric surgery which are often marginalised to the private sector, this can mean that there is little opportunity for integration with public services.

The ACPS and its members are committed to research, reflective practice and clinical improvement, through the College's own quality assurance activities, and will revise and review this process over time.

## 4. References

1. Australian Government Productivity Commission. Australia's Health Workforce: Research report. Canberra, Productivity Commission, 2005.
2. Task transfer: the view of the Royal Australasian College of Surgeons. *Medical Journal of Australia* 2006 185(1):25-26
3. Brooks P, Robinson L, Ellis N. Options for expanding the health workforce. *Australian Health Review* 2008 32 (1): 156-60
4. Duckett SJ. Health workforce design for the 21st century. *Australian Health Review* 2005; 29: 201-210.
5. Kenny A, Duckett S. A question of place: medical power in rural Australia. *Social Science & Medicine* 2004 58: 1059-1073
6. Oldmeadow LB, Bedi HS, Smith JS, et al. Experienced physiotherapists as gatekeepers to hospital orthopaedic outpatient care. *Medical Journal of Australia* 2007; 186: 625-8.
7. Smith TN, Baird M. Radiographer's role in radiological reporting: a model to support future demand. *Medical Journal of Australia* 2007; 186: 629-31.
8. Lewis JM. Being around and knowing the players: Networks of influence in health policy. *Social Science & Medicine* 2002 62: 2125-2136
9. Duckett SJ. Interventions to facilitate health workforce restructure. *Australia & New Zealand Health Policy* 2005; 2: 14
10. Helm R, Ravi K. Podiatric surgery and orthopaedic surgery: a customer satisfaction survey of general practitioners. *The Foot* 2003 13: 43-54
11. Larkin G. Occupational Monopoly in modern medicine. 1983 London, Tavistock Publications
12. Kilmartin T. Podiatric Surgery in a Community Trust; a review of activity, surgical outcomes, complications and patient satisfaction over a 4 year period. *The Foot* 2002 11: 218-227
13. Bennett PJ, Patterson C, Dunne M. Health related quality of life following podiatric surgery. *Journal of the American Podiatric Medical Association* 91: 164-173
14. Borthwick A. Challenging Medicine: the case of podiatric surgery. *Work, Employment & Society* 2000 14: 369-383
15. Parroy S. Joint effects: the impact of Allied Health Professionals on orthopaedic and musculoskeletal service change in Scotland. 2005
16. Farrar MJ, Pickard JM, Binns MS. Ambulatory day case forefoot surgery. *Ambulatory Surgery* 1995 3(2): 97-99
17. Bennett PJ. Prevalence and type of foot surgery performed in Australia. *The Foot* 2007 17 (4): 197-204
18. Bligh G, Rick M. Whose best foot forward? *Lancet* 1997 350(supp III) 21
19. Brooks PM, Lapsley HM, Butt DB. Medical workforce issues in Australia: "tomorrow's doctors — too few, too far". *Medical Journal of Australia* 2003; 179: 206-208

20. Hood IS, Kilmartin T, Tollafield D. The effect of podiatric day care surgery on the need for National Health Service chiropody treatment. *The Foot* 1994 4 (3): 155-158
21. Mangan J, et al. A multidisciplinary approach to foot surgery waiting lists. *The Foot* 1992 2 (1): 29-33
22. Skipper JK, Hughes JE. Podiatry: a medical care specialty in quest of full professional status and recognition. *Social Science & Medicine* 1983 17 (20): 1541-1548
23. Van Gils CC, et al. Amputation prevention by vascular surgery and podiatry collaboration in high-risk diabetic and non-diabetic patients: The Operation Desert Foot experience. *Diabetes Care* 1999 22: 678-683
24. Van der Wyden MB. Task transfer: another pressure for evolution of the medical profession. *Medical Journal of Australia* 2006 185(1): 29-31
25. Del Mar CB, Dwyer N. A radical new treatment for the sick workforce. *Medical Journal of Australia* 2006 185(1): 32-34
26. Australian Society of Orthopaedic Surgeons. Media release 9 December 2005: Cutting of bone and tendon should be done by doctors with special training. [Internet] accessed 13/05/08 <  
[http://www.asos.org.au/index.php?subdir=media\\_rel/2005/&file\\_name=9dec05](http://www.asos.org.au/index.php?subdir=media_rel/2005/&file_name=9dec05)>
27. Royal Australasian College of Surgeons. Submission to NSW Health Regarding the Performance of Podiatric Surgery in NSW. [Internet] accessed 13/05/08 <  
[http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/ReportsandPublications/Reports/ReportstoExternalAgencies/NSW\\_Submission.pdf](http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/ReportsandPublications/Reports/ReportstoExternalAgencies/NSW_Submission.pdf)  
[http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/ReportsandPublications/Reports/ReportstoExternalAgencies/NSW\\_Submission.pdf](http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/ReportsandPublications/Reports/ReportstoExternalAgencies/NSW_Submission.pdf)>
28. Slater K. Letter to the editor. *The Quarterly* 2007 40(3) [Internet] accessed 13.5.08 <  
[http://www.racma.edu.au/index.php?option=com\\_docman&task=doc\\_download&gid=203](http://www.racma.edu.au/index.php?option=com_docman&task=doc_download&gid=203)>
29. NSW Health. Media release: State and territory governments seek ACCC intervention to ensure more surgical training places. 26 Sept 2005 [Internet] accessed 13/5/08  
[http://www.health.nsw.gov.au/news/2005/20050926\\_01.html](http://www.health.nsw.gov.au/news/2005/20050926_01.html)
30. Weiner JP, et al. Elective foot surgery: relative roles of doctors of podiatric medicine and orthopaedic surgeons. *American Journal of Public Health* 1987 77:987-992