



13 February 2020

Department of Employment, Skills, Small and Family Business

Dear Sir/Madam,

ASA Submission to the Consultation on draft proposed occupation lists

Introduction:

In relation to the current review of the Skilled Migration List being conducted by the Department, the Australian Society of Anaesthetists (ASA) has been asked to provide data which would demonstrate that Metropolitan areas (MMM 1 and MMM2) have an oversupply of Specialist Anaesthetists in both the public and private sectors, and that there is otherwise an adequate anaesthesia workforce in non-metropolitan areas.

When the ASA met with the Department on 27 November 2019, we referenced the Australian Government Department of Health report which stated¹ that the Specialist Anaesthesia workforce “is in balance, with the potential to shift into oversupply if trainee numbers are increased or if there is not a decrease in International Medical Graduates (IMGS)”.

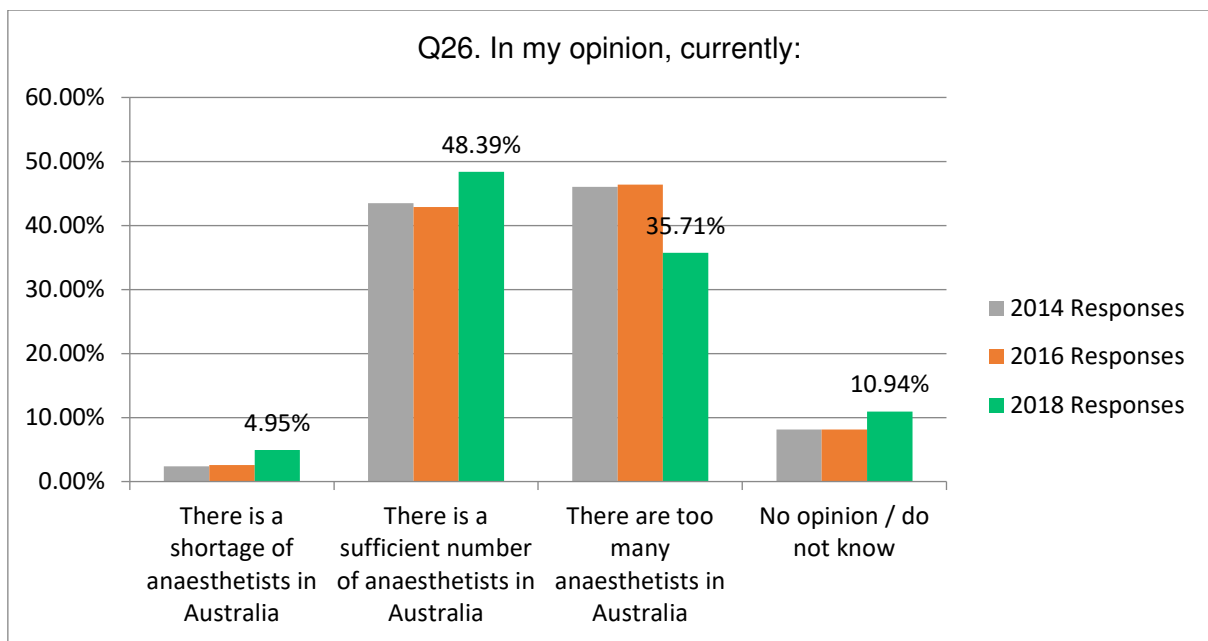
The ASA itself holds that the Specialist Anaesthesia workforce is already in oversupply at a national level. Our position is underwritten by our biannual surveys of our Specialist Anaesthetist members, which achieve a response rate of around 40%.

(1) Australia's Future Health Workforce – Anaesthesia. April 2016. Australian Government Department of Health. Accessed April 2017

Findings:

National workforce adequacy:

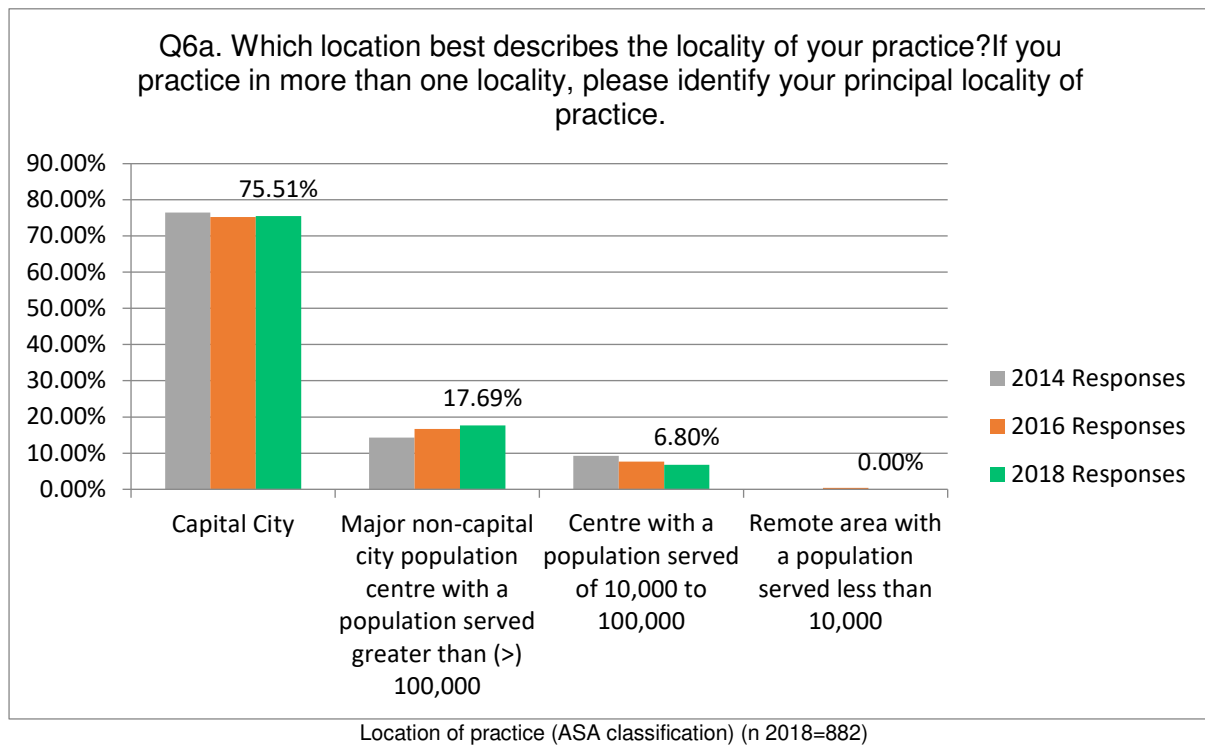
As stated above, the ASA holds that the Specialist Anaesthesia workforce is already in oversupply at a national level. The consistent findings of the previous three ASA member surveys are extracted from the survey Q26 below. Fewer than 5% of responders believe that there is a shortage of anaesthetists in Australia, with more than a third believing that there are too many.



National anaesthesia workforce adequacy: all responders (n 2018=868)

Location of practice:

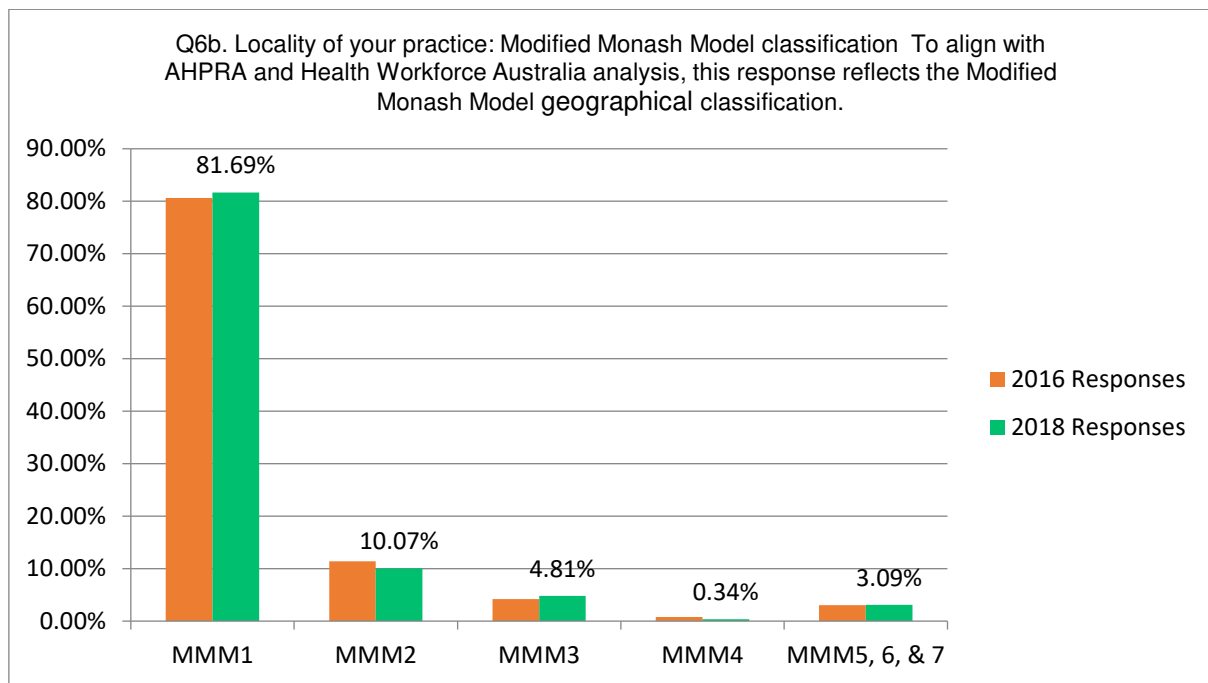
In earlier surveys, the ASA defined location of practice in four geographical categories which were known within the specialty of anaesthesia to reflect the distribution of anaesthetists in this country. The following graph (labelled 6a, as per the 2018 survey) represents location of practice using this classification.



Location of practice by MMM:

In the two most recent surveys, ASA has also used the Modified Monash Model (MMM) to enable ASA survey data to be better compared with data acquired by the Department of Health and other agencies through information provided through the annual medical registration / reregistration process.

Location of practice as defined by MMM is shown in the following graph (6b).

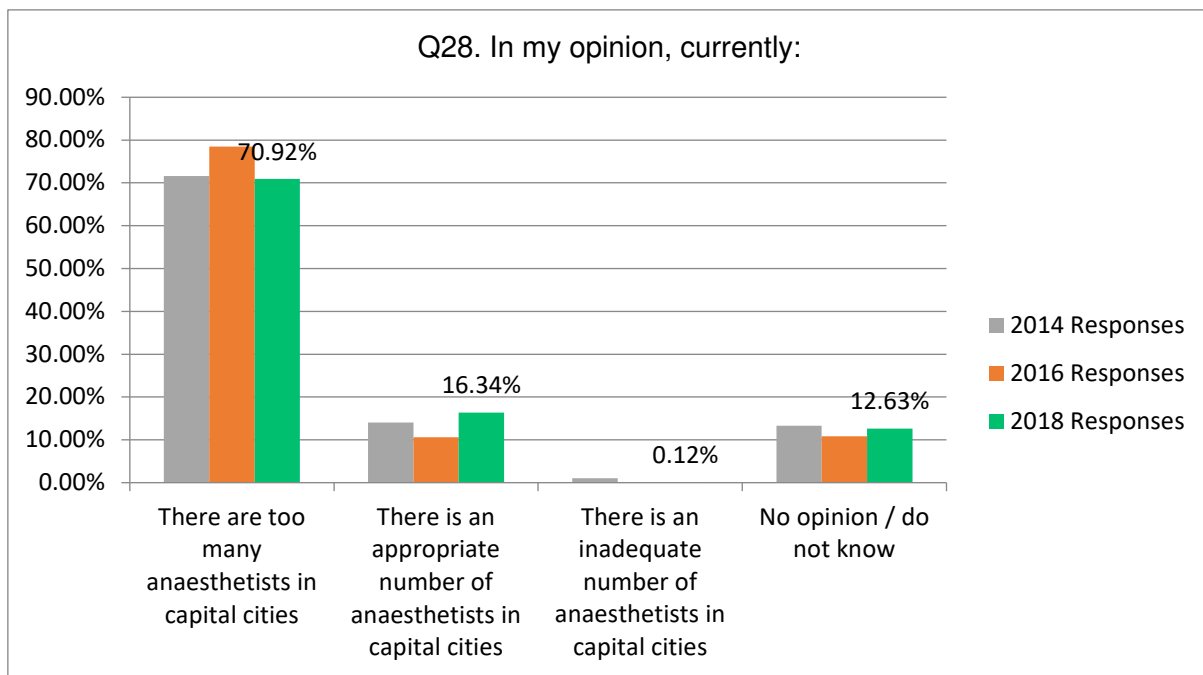


Location of practice by MMM (n 2018=874)

Is there a capital city oversupply of Specialist Anaesthetists?

In addressing what is asserted by the ASA to be an oversupply of Specialist Anaesthetists in Metropolitan areas (MMM 1 and MMM2), in both the public and private sectors, graph Q28 below reports the subjective views of anaesthetists actually practising in capital cities in public, private or blended practices, against the ASA geographical classification.

Formal analysis against MMM locality has not been conducted, noting that Hobart is not in MMM1, but ASA believes that that there is an overwhelming subjective belief that “there are too many anaesthetists in capital cities”.



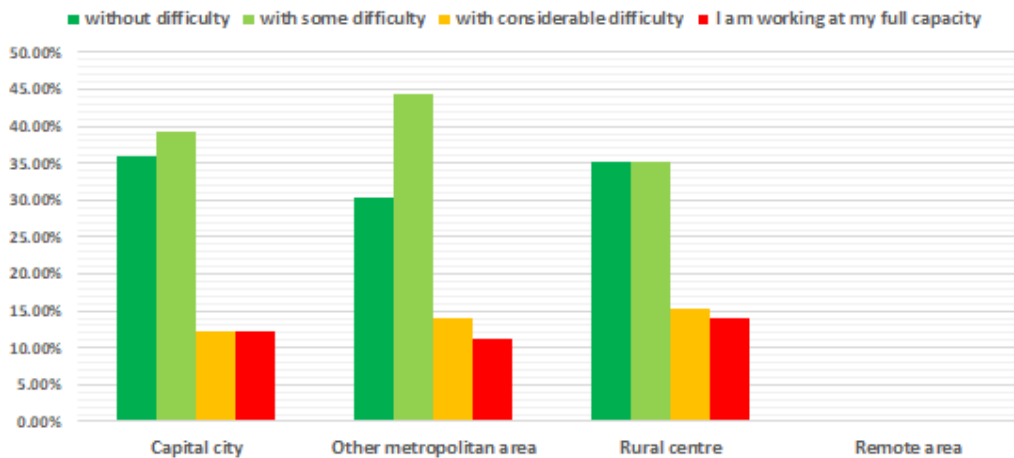
Capital city anaesthesia workforce adequacy: Capital city responders (n 2018=666)

Capacity of Specialist Anaesthetists to increase caseload:

In attempting to bring objectivity to this position, responders were asked whether they could increase their current caseload. The findings are shown in graph Q20 below, with three quarters of capital city responders being able to increase the caseload without difficulty, or with some difficulty. This is taken by the ASA to add support to its position that there is otherwise an adequate anaesthesia workforce in capital cities.

Of considerable interest, though not directly related to the capacity of capital city practitioners to increase caseload, was the finding that more than 70% of specialist anaesthetists in rural centres reported being able to increase their current caseload without difficulty or with some difficulty. This is also taken by the ASA to add support to its position that there is otherwise an adequate anaesthesia workforce in non-metropolitan areas.

Q20. "Could you increase your current caseload?"



Ability to increase caseload: by location of practice (n 2018=873)

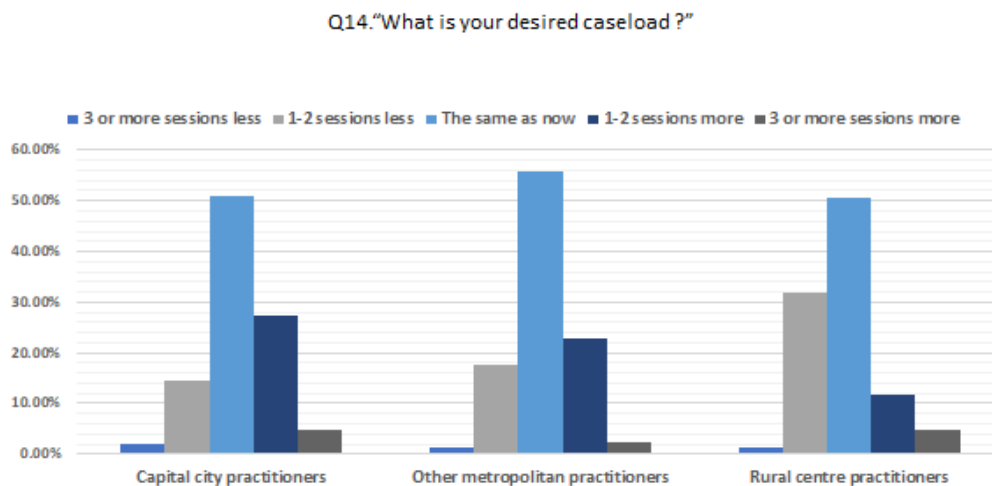
Workload Preference of Specialist Anaesthetists:

Question 14 also explored the question of whether Specialist Anaesthetists could increase their caseload, and also sought to provide some objectivity, this time through quantitative assessment, with practitioners in various geographical locations addressing desired caseload in their locations of practice.

Commonly used qualitative measure of anaesthesia workload is a “session”, where a session can be anything from a morning to a very long afternoon, with 10 sessions approximating one weeks work.

Responders were asked to address their preference (Q14) for a reduced, unchanged, or increased caseload, with twice as many capital city responders wanting an increased rather than the decreased caseload, though with half being satisfied with their current caseload. This is again taken by the ASA to add support to its position that there is otherwise an adequate anaesthesia workforce in capital cities.

Conversely, anaesthetists in rural centres were twice as likely to want a decreased caseload, though again; half were satisfied with their current caseload. This suggests to the ASA that there is overall an adequate anaesthesia workforce in non-metropolitan areas, but that some areas in some practitioners may require workforce augmentation.

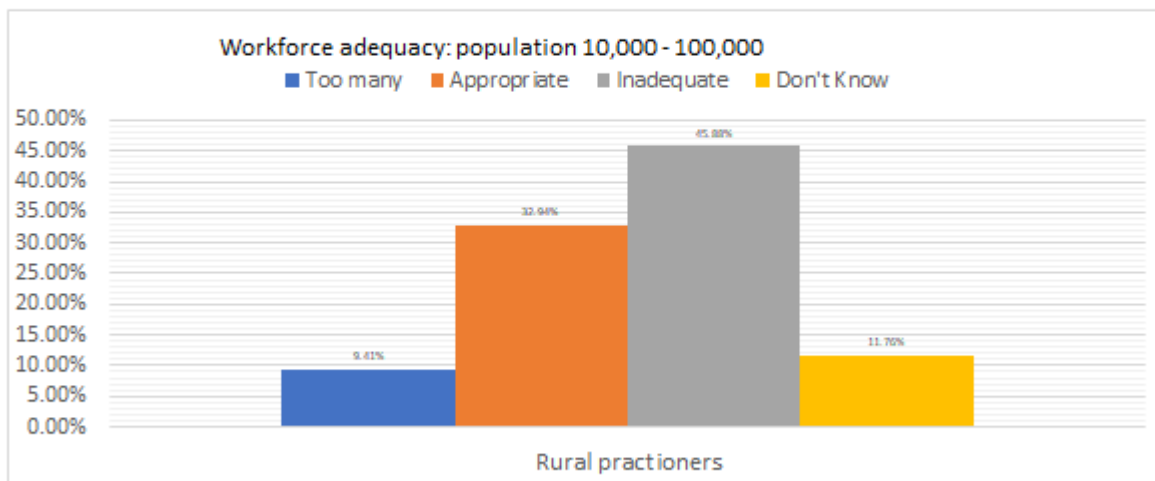


Workload preference: by location of practice (n 2018=874)

Workforce adequacy: the local view:

Q30 shows that half of responders in centres serving populations of 10,000 to 100,000 believe that there is an inadequate number of anaesthetists in those areas. Although this does not seem to reflect the findings reported in Q20 above, it does corroborate the findings of Q14 in that practitioners serving centres with a population of 10,000 to 100,000 were twice as likely to want a decreased rather than increased caseload.

Q30. Workforce adequacy: the local view



Non-metropolitan anaesthesia workforce adequacy: Non-metropolitan responders (n 2018=?)

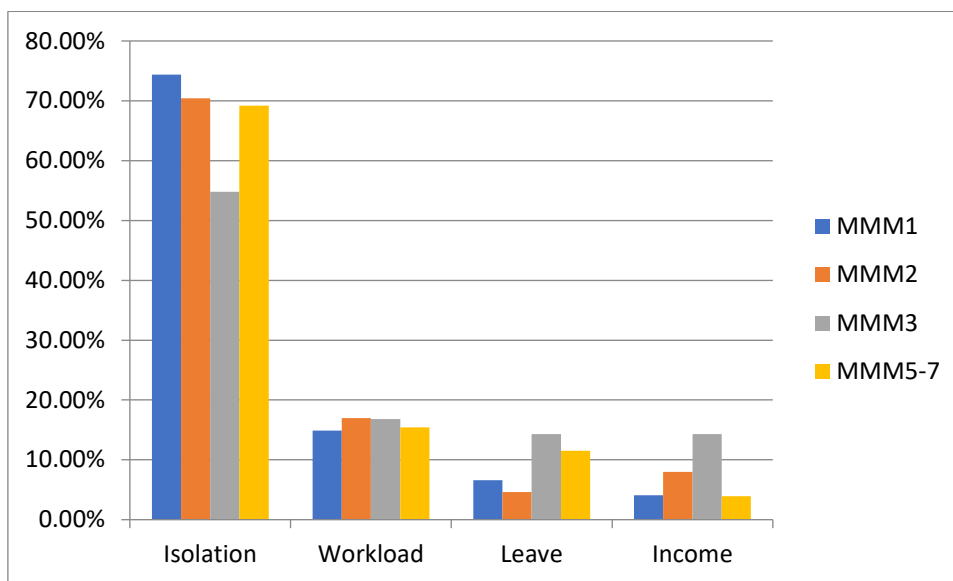


Impediments to recruitment and retention in smaller centres:

It has long been reported and accepted that professional isolation is the main impediment. The views of practitioners in the various MMM locations in relation to this issue is shown in the graph below, confirming the large majority practitioners in all locations view isolation as the main impediment.

However, workload (sometimes too little rather than too much, but also the varied and unpredictable acuity of the case-mix) is an appreciable consideration.

Obviously, “local solutions” which best address these impediments in what are predictably locations with particular local circumstances are most likely to benefit recruitment and retention, though these are beyond the reach of this brief.



Rating of perceived impediments to rural and remote practice (n 2018=853)

Summary:

The ASA position is that

- Metropolitan areas MMM 1 and 2 have an oversupply of specialist anaesthetists in the public and private sectors, this position being underwritten by workforce survey objective metrics and subjective opinion. The deleterious effects of an “oversupply” of specialist anaesthetists include narrowing of case-mix and loss of “generalism”, and the potential loss of skills (cited by 20% of survey respondents).
 - Consequently, the ASA believes that visas which allow IMGs to enter specialist anaesthesia practice in these areas should no longer be issued.
- Overall, there is an adequate Anaesthesia workforce in non-metropolitan areas. This finding is also supported by the responses to the survey questions analysed against location MMM 3. Non-metropolitan facilities operate in different fashions, with some having chronic difficulties in providing anaesthesia services, whereas others operate smoothly. Focused examination suggests that the non-metropolitan anaesthesia workforce is in oversupply in some areas, and deficient in others.
 - The ASA believes that visas which allow IMGs to enter specialist anaesthesia practice in areas MMM 3 should only be granted when there has been an intensive assessment of need, with as mentioned when the ASA met with the Department, “good faith” dealings between would-be visa sponsors and the local incumbent practitioners.
- Any shortage or maldistribution of anaesthetists in nonmetropolitan areas will not be solved by overseas recruitment, and that there are net losses to both the countries of origin and to this country.

If you require any further information or would like to discuss further, please do not hesitate to contact Ms Jacintha Victor John, Policy Manager on (02) 8556 9720. Alternatively, you can email jvictorjohn@asa.org.au in the first instance should you require additional information.

Yours sincerely,



Dr Suzi Nou
President
Australian Society of Anaesthetists.