SAFE HANDS

Our Surgeons and Anaesthetists do amazing work in challenging environments

Bold reform required, not patching the cracks

Dr Danielle McMullen
Federal AMA President

Australians deserve affordable and accessible care – whether in public hospitals or the private sector. Our mixed system is one of the reasons Australia ranks among the best in the world, but it is under pressure due to decades of government inaction and the lack of structural reform.

Years of underinvestment in Medicare and hospital funding have left patients paying more out of their own pocket or delaying care altogether. The Medicare Benefits Schedule has failed to keep pace with costs, with indexation lagging for decades and even frozen for several years from 2013.

Like all sectors across our economy, costs rise year on year; yet patient rebates have seen barely more than a sprinkle of indexation – they are nowhere near keeping up with inflation. So, in real terms, there has been a cut to the portion of patient care the Government chooses to subsidise.

Doctors and medical practices face rising overheads – staff wages, insurance, utilities, leasing, IT and medical equipment – all of which have increased by multiples of the Medicare rebate indexation. This problem is compounded by the Medicare freeze and rebates never catching up to where they should have been, resulting in a widening gap between treatment costs and what Medicare covers – a gap that now spans the entire health system nationwide.

The chronic underfunding of public hospitals also has a significant knock-on effect on our private system. When public hospitals can't meet demand, patients turn to private care for timely treatment. The private sector now handles two out of every five hospital admissions and more than two in three planned surgeries.

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Private hospitals and specialists absorb this overflow – but instead of receiving recognition they are copping financial pressures and the blame for patient out-of-pocket costs. The private sector offers our community choice – it was never designed to fill the cracks of our overstretched public system.

This combination of rising costs, shrinking coverage and mounting financial pressure is placing the entire private health system under strain. There is now an urgent need for reform to protect patient access and choice, and to ensure the sustainability of our entire health system.

At the same time, many private hospitals are warning that their existing contracts with private health insurers no longer cover the cost of care, while many of these insurers are posting large net profits.

Since 2020, more Australians have been purchasing private health insurance, and today more Australians hold hospital treatment cover than ever before. But a closer look tells a different story: fewer policies now offer top-level coverage, exclusions are at record levels, and the overall value of private health insurance is eroding.

The AMA's 2025 *Private Health Insurance Report Card* reveals a system increasingly failing to deliver value for money. Premiums have risen sharply – outpacing inflation, wage growth and Medicare indexation – while coverage has narrowed.

Only 15 years ago, few hospital policies contained exclusions; but by 2018 most hospital insurance policies had shifted to include them. That trend of exclusions has continued to rise, with 68.4% of private hospital treatment policies no longer covering all types of care, meaning many Australians are paying more, but are covered for less.

The tiered product system introduced in 2020 – basic, bronze, silver and gold – was designed to simplify choices, but has instead created confusion and contributed to underinsurance. Since then, the number of Australians with gold-tier cover has fallen by 360,000 to just 743,000, despite overall growth in health policy coverage. Many Australians have shifted to silver or bronze policies, which often exclude critical services. Meanwhile, those seeking to purchase insurance for the first time are being priced out of the market for gold-tier policies, which have become prohibitively expensive.

Gold-tier policies, which provide the most comprehensive coverage, are particularly susceptible to "phoenixing" – a term used when insurers close an existing policy and replace it with a nearly identical one at a higher price. This tactic bypasses the regulated premium-increase approval process, allowing insurers to raise costs without ministerial oversight and leaving consumers paying more. The AMA welcomes legislation introduced in February to outlaw this practice.

At the same time, a smaller share of premiums goes towards covering the cost of care for policyholders. In the 2024-25 financial year, insurers retained nearly 16% of hospital premiums as gross margin – amounting to $3.62 billion – meaning only 84% of premium revenue was paid out as benefits reimbursing care. The AMA continues to call for insurers to be required to return at least 90% of private health insurance premiums to consumers in the form of benefits for treatment.

Every year, these AMA Private Health Insurance Report Cards expose where the system is failing Australians, driving accountability and change, and we will continue fighting hard for doctors, using the strength of our advocacy and influence to push for lasting improvement across the health system.

But these steps, while important, are not enough. There is an urgent need for real reform to tackle the structural issues, which have been ignored for too long, to ensure the sustainability of our entire health system and to protect patient access and choice.

The next reform must be bold. We need a Private Health System Authority – an independent body to lead sector-wide reform. This authority would ensure all stakeholders are heard, and that changes are fair, transparent and sustainable. It would provide the oversight needed to restore trust and deliver value for patients.

Australia's healthcare system is built on a unique balance of public and private services that gives Australians choice and access, but that balance is fragile. If Medicare rebates remain stagnant, public hospitals continue to struggle, private hospitals remain under pressure and insurers withhold value from Australians, then more patients will miss out on the care they need. That is not the future Australia should accept. ■

The three questions to ask patients over 65

Roisin Sweeney

Injury Matters, General Manager – Injury Prevention

Did you know that a Western Australian is hospitalised every 16 minutes, presents to ED every 12 minutes, and dies every 17 hours due to a fall?

Falls and fall-related injuries are a significant public health issue in WA, ranking as the leading cause of injury death, hospitalisation and ED attendance.[1] If we don't take action, falls will have a growing impact on our community. We all have a role to play in preventing falls.

In 2023, there were 33,506 hospitalisations due to falls in WA, with older adults accounting for over two-thirds (22,607) of these hospitalisations.

The main injury diagnosis for falls hospitalisations in 2023 were injuries to the lower limbs (32%), injuries to the head and neck (26%), and injuries to the upper limbs (25%).[1]

Fractures were the leading reason hospital patients required treatment following a fall, accounting for 43% of all hospitalisations. Other leading causes were wounds (13%), superficial injuries (8%) and intracranial injuries (7%).

Older adults commonly spend an extended period in hospital following a fall, with older adults spending nine days on average, compared to 1.5 days among people aged 0-4 years in 2023. This extended period in hospital provides a valuable opportunity for health professionals to support their recovering patients and prevent future falls.

Beyond the burden on our health system, falls can lead to a loss of independence, reduced mobility, a fear of falling, and negatively affect an older adult's overall quality of life.

It is likely the number of fall-related injuries will continue to grow in WA due to our ageing population and the increasing prevalence of multimorbidity, polypharmacy and frailty among our older adult population.

The good news is that many falls are preventable, and health practitioners play a key role in identifying risks and initiating early intervention.

According to the World Falls Guidelines,[2] there are three questions health practitioners should ask when treating anyone over the age of 65 to reduce their risk of falls:

1. **Have you fallen in the past year?**
2. **Do you feel unsteady when standing or walking?**
3. **Do you worry about falling?**

If a patient answers yes to any of these questions, Injury Matters' Stay On Your Feet® falls prevention program is a valuable resource for information on referral pathways, free brochures and support for your patient.

A fall can occur due to personal, environmental or behavioural risk factors. While a single risk factor can cause a fall, falls are more often caused by the combination of multiple risk factors. Asking clients these three simple questions can lead to the discovery of further risk factors, such as poor nutrition or medication interactions, and prevent a life-changing fall.

Research consistently shows that targeted, multifactorial interventions can significantly reduce an older adult's risk of falling. Effective strategies include:[3]

- building balance, strength and mobility;
- completing a medication review yearly, or after a change in health status;
- removing hazards in and around the home;
- having an annual vision assessment and managing visual impairments; and
- seeing a podiatrist if experiencing painful feet.

Injury Matters works in partnership with local governments, health services and community organisations across WA to support access to fall-prevention initiatives. Referral to these initiatives can reduce falls, improve mobility, and help older adults maintain independence. There are several free or low-cost initiatives available to support your patients.

All it takes is three simple questions that could make all the difference. ■

More resources

- Injury Matters' Stay On Your Feet® program
- Australian Commission on Safety and Quality in Health Care – Falls Guidelines
- Falls Prevention Alliance Australia

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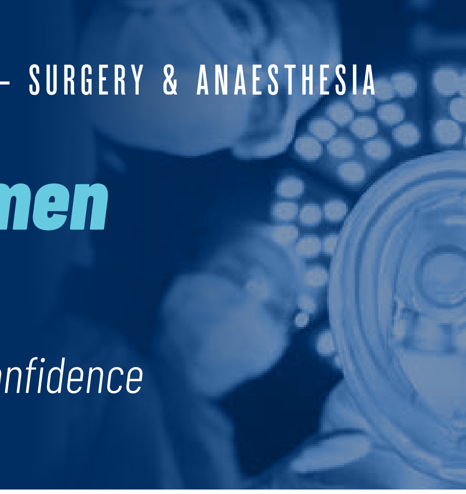
References available on request.



Weight-loss drugs drive rise in men seeking gynecomastia surgery

More men are opting for chest surgery to restore their body confidence after losing up to 40kg of weight, writes Martin Saxon

The boom in the use of Ozempic and other GLP-1 drugs has contributed to a significant increase in the number of men choosing to have gynecomastia surgery to improve their body image after major weight loss, according to a leading breast surgeon. Gynecomastia can be caused by hormonal changes, genetics, medications, long-term weight fluctuations and ageing.

Associate Professor Sanjay Warrier, a leading breast health and breast cancer surgeon, says that with Australia's soaring rates of obesity and the corresponding shift towards medical weight-loss treatments, more men are noticing excess breast tissue once the surrounding fat disappears.

"When men lose weight quickly, the underlying breast gland can become far more obvious," he explains. "No amount of gym work will remove glandular tissue. That can be very frustrating for patients who have worked extremely hard to lose weight and improve their health."

A/Prof Warrier says the demand, which has grown sharply over the past two years, is driven by a combination of medical, aesthetic and lifestyle factors, including rapid weight loss from Ozempic and other GLP-1 medications, hormonal changes, genetics, and long-term body image concerns.

"We are seeing more men than ever seeking treatment for gynecomastia," he says. "For many, the condition has become more noticeable after substantial weight loss. Medications like Ozempic are helping people lose weight quickly, but they can also leave behind loose skin and residual glandular tissue that cannot be fixed with diet or exercise alone."

A/Prof Warrier says men who lose between 15 and 40 kilograms on GLP-1 medications often report sagging skin, stubborn chest fullness and reduced confidence, which leads them to seek surgical correction; and that the increase in presentations is not for purely cosmetic reasons. For many, gynecomastia is physically uncomfortable and psychologically distressing. The condition can also significantly affect self-esteem, posture, clothing choices and social confidence, and many men avoid situations such as swimming or exercising in public.

"This is not a vanity issue," he says. "Gynecomastia can have a real impact on body image, mental health, and quality of life. Many men tell me they have lived with embarrassment or discomfort for years before they finally seek help."

The psychological burden, he says, can be particularly heavy for men who have recently improved their health and feel the last remaining barrier to confidence is their chest. Gynecomastia surgery removes excess glandular tissue, fat and, in some cases, excess skin to create a flatter, more masculine chest contour. The procedure is tailored to the patient's anatomy and may involve liposuction, direct excision, or a combination of both.

"The goal is to restore confidence and create a natural, proportionate chest shape," A/Prof Warrier says. "For men who have carried this concern for decades, the results can be life changing."

Recovery times vary, but most patients resume normal activities within a few weeks. A/Prof Warrier cautions men against assuming diet, chest workouts or supplements can fix the problem.

"If the tissue is glandular, no amount of training will remove it," he says. "That's why so many men who are extremely fit or have lost large amounts of weight still struggle with this issue."

A/Prof Warrier says men should seek an assessment from a qualified specialist to determine the cause and appropriate treatment. While gynecomastia surgery was once a topic men rarely discussed, he says attitudes are changing rapidly.

"Men are becoming far more open about their health, their body image, and the psychological benefits of feeling comfortable in their own skin," he says. "The stigma is disappearing, and that's a very positive shift."

In addition to breast health and surgical work, the Sydney-based surgeon dedicates considerable time to research exploring and developing advancements in breast cancer detection and treatments to improve outcomes for patients. He also co-developed Australasia's first Master of Advanced Surgery (Breast Surgery), which is delivered through the University of Sydney. ■

cpd home

EA

Hi-tech answer to pre-surgery heart checks

Clinical trials of non-invasive tests have hundreds of patients enrolled, writes Martin Saxon

Two hi-tech medical devices being clinically tested at Fiona Stanley Hospital in Perth are designed to be a quick, easy and non-invasive way to check a patient's heart health before surgery.

The devices have been developed by **Dr Hadi Afsharan** at the Harry Perkins Institute of Medical Research, supported by more than $1.8 million in funding from the State Government's Future Health Research and Innovation (FHRI) program and the University of WA.

One device uses safe, light-based technology to capture high-resolution images of the retina to identify markers of cardiovascular disease; the other is a small electromagnetic sensor that can check heart function by detecting telltale movements in the jugular vein without even touching the skin.

"All patients who go through surgery need to be tested for any sort of cardiovascular disease, including heart disease," Dr Afsharan says.

"Most of the tests now are invasive, but the technologies that we have, though still in the research phase and in clinical trial, can eventually, if successful, replace these methods."

Dr Afsharan earned his PhD in Biomedical Engineering from UWA in 2023, and it was his thesis – *Development of Polarisation-Sensitive Optical Coherence Tomography [PS-OCT] for Application in Medical Diagnosis* – that led to his research into using eye imaging to detect heart disease.

"It was during my PhD that we developed the system," he says.

"PS-OCT is a way to detect any kind of heart disease through the eye, by looking at the retina at the back of the eye. We look at the blood vessel walls – how thick they are and their organisational integrity. We also look at the nerve layers because the retina is full of nerves, and what we see are electrical pulses going through those nerves to the brain.

"Heart disease can affect both the blood vessel walls and the nerves. A person with coronary heart disease has blood vessels of the heart that are blocked and filled with plaque. The same thing happens all over the body and in the retina as well.

"Because the retina is the only tissue inside the body that can be seen non-invasively and through optical methods directly, it can be used as a proxy.

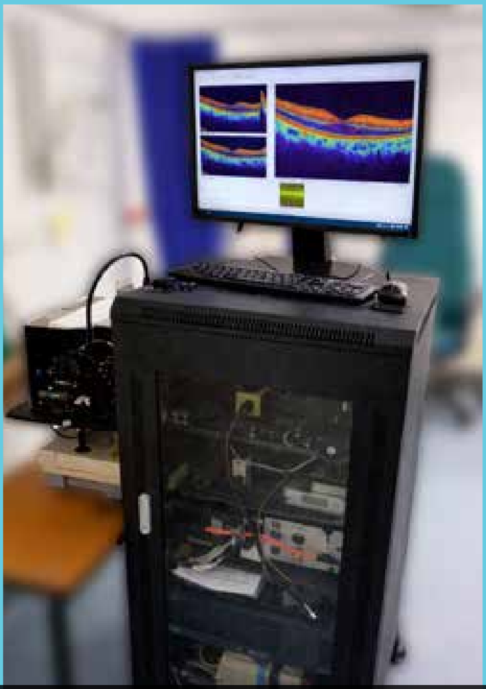
"If the plaques are generating in the coronary arteries of the heart, the same plaques are building up in the retinal blood vessels as well. Our system can distinguish the plaques in the retina as a thickening of the blood vessel walls.

"The system is equipped with AI and deep learning, and it can analyse the images and spit out the result that the doctors and clinicians need in just a few seconds. So it could be done exactly prior to anaesthesia or surgery, but I think to be in the safe zone, it's better to do the test two or three days before the surgery."

The PS-OCT system is in the second year of clinical trial at Fiona Stanley Hospital. The machine is housed in the CAT lab, and the 200 or so patients who have registered for the trial have heart checks and angiograms at the same time as having retinal images taken for comparison. The aim is to register another 150 participants this year.

Jugular Venous Pulse (JVP) sensor, recording the flow inside the veins of the neck.

Dr Hadi Afsharan – Perkins Research Fellow, Cardiovascular Science & Diabetes.



First prototype PS-OCT system, at Fiona Stanley Hospital, operator view.

> **“The system is equipped with AI and deep learning. It can analyse the images and spit out the result that doctors and clinicians need in just a few seconds; so it could be done exactly prior to anaesthesia or surgery.**

“The system is still bulky. It needs a little bit of effort to move it around,” Dr Afsharan says. “But we have a clear pathway to make a miniaturised version, and we are working towards putting it in a suitcase so we can move it around in the hospital and deploy it in eye clinics, even in remote areas. So our aim is to make it portable and accessible to everyone.”

The other device is a frequency-modulated sensor, commonly used in cars and the robotics industry, that will test the pressure in the jugular vein to detect heart function. It can detect tiny movements of the vein without touching the skin.

“This was started by a student at the University of Sydney three years ago. We then embarked on this study two years ago when the researchers came to us saying they had this technology and asked if we thought we could use it in a clinic on human beings. And we said yes,” Dr Afsharan recalls.

“Then we collaborated, and in December we started a clinical trial. We already have some data from healthy people, and it's working.”

The Phase I trial will ultimately involve 50 patients. Three patients in the Coronary Care Unit at Fiona Stanley Hospital have already been recruited.

Dr Afsharan says the goal is to make assessment of heart congestion easier, more accurate, and accessible in everyday clinical care. He says observational diagnosis of the jugular is often not accurate, and the “gold standard” test, by inserting a catheter through the patient's veins, is invasive.

“Our sensor is able to distinguish the minor displacements of the skin that are happening because of the blood flowing inside that jugular vein,” he explains. “In heart failure patients, the flow is restrained; and because of that, the displacement of the skin is different than in normal people.”

The frequency of the sensor, which is only 2cm by 2cm, has been modified so it detects a displacement at close range, from about 10cm away.

“We are planning this year to have the sensor embedded inside a neck pillow, the sort that people use in airports and on airplanes, so patients can comfortably wear them everywhere, even when they are sleeping,” Dr Afsharan says.

“It will beep or send a notification to your phone if something is wrong with your heart pumping blood. You can send a notification to your clinician or your doctor. This is the idea. Same thing can happen in pre-surgery situations.

“It will do everything by Wi-Fi. You just add a small dongle to the circuit, and it will send everything to a computer or a mobile phone to do the processing.” ■

cpd home
EA

Young people help set priorities in paediatric anaesthesia research

Dr Aine Sommerfield
Perth Children's Hospital Clinical Research Program Manager

Australian children and young people have for the first time been given the opportunity to share their priorities for research in paediatric anaesthesia. Safety, pain and anxiety were their top three concerns, but they also identified better communication from doctors, and emergence agitation and "feeling strange" when waking up after anaesthesia, as important to them.

These findings are the result of a world-first project led by the Anaesthesia Research Team at Perth Children's Hospital (PCH), headed by AMA (WA) member Prof Britta Regli-von Ungern-Sternberg AM FAHMS.

The increased emphasis on patient and family-centred clinical care has driven a new consumer engagement approach in research.

In anaesthesia research, as in many medical areas, research focus has been mainly determined by a combination of the researcher's expertise and personal research interests. However, interest has turned to working with consumers to identify their research priorities.

The National Health and Medical Research Council guidelines dictate that, at a minimum, consumers and community should be involved in four key stages:

1. Determining research priorities, including what should be researched.
2. Developing research concepts/hypotheses/questions and designing research projects.
3. Research conduct including participant recruitment, consent and responsibility (ethics, governance), and oversight or governance of the conduct of the research.
4. Reporting, communications, and publication/dissemination and translation.

The PCH team began by partnering with 850 parents/carers across Australia to identify their top 10 research priorities in a multistep process involving online surveys and a consensus workshop. This gave Australian consumers the opportunity to shape the paediatric anaesthesia research agenda. Their top priorities were safety, anxiety, and pain management.

Since completing the project, the research team has developed new studies addressing the top priorities for parents, such as the STARFISH project investigating the use of sensory toys to help manage children's pre-operative anxiety, which addresses the number 2 and number 7 research priorities for parents.

While this was an important exercise, the team was aware that the concerns of parents/carers may not always reflect those of their child. Therefore, we decided to repeat the project, but this time working with children and young people aged from six to 18 years.

As the person who leads the consumer prioritisation projects for the team, I know there was some concern around whether we could engage enough children and teens, particularly as a key first step involves consumers entering research ideas in free text in an online survey. We were a bit worried that we wouldn't get ideas from the children and young people, so we added in an extra step of an online community conversation in parallel to the idea-generating survey. These two combined ensured we had sufficient research ideas to move the project forward.

After an interim prioritisation survey and a final consensus workshop, both held online, the final top 10 priorities of Australian children and young people was complete. The project, which has engaged more than 350 children and young people from all Australian states and territories, was a great success; and our initial concerns were not realised. In fact, the young consumers were engaged, passionate, and very keen for their voices to be heard.

Parents and researchers discussing research priorities for children having anaesthesia at the consensus workshop in September 2021.

The priorities of children and young people differed from those selected by the parents/carers. In fact, there were only five common priorities in the top 10 lists when those of children and young people were compared to those of parents/carers. Other interesting differences included the importance that children and young people placed on the effects of anaesthesia on mental and emotional health, how medicines worked differently between people, and whether children felt pain differently.

These prioritisation projects undertaken by the Anaesthesia Research Team have made a valuable contribution, not just with guiding research, but also matching the needs of funding agencies who are increasingly placing importance on meaningful engagement with consumers.

Following on from these projects, the team has worked with parents/carers, paediatricians, GPs, and Down Syndrome WA to identify the top 10 consumer research priorities for children with Down syndrome. The top two were:
1) developing a "gold standard" model of care, including screening health checks across all levels of care; and
2) sleep quality (including obstructive sleep apnea, snoring, breathing problems, circadian rhythm).

Another concern that emerged for parents was the issue of atlantoaxial instability. Although it is a rare condition, sports organisations at all levels commonly request neck X-rays from athletes/participants with Down syndrome. To date, no studies have assessed cervical screen radiographs as a valid screening tool, and there is little evidence to show that radiographs are useful for identifying at-risk children or preventing spinal cord injuries. This has contributed to elevated concerns and avoidance of activities. Advocacy that clearly articulates the current evidence and research that further describes the pathogenesis of atlantoaxial instability is considered a priority for parents/carers of children with Down syndrome.

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Another recently completed prioritisation project was conducted for children requiring neonatal surgery, an often-neglected group in neonatal research. These children are a distinct cohort, with 1,108 neonates in Australia undergoing major surgery in 2021, defined as surgery opening a body cavity.

Continued on page 18.

Continued from page 17.

Members of the Down syndrome prioritisation study team – Dr Ellen Taylor, Dr Aine Sommerfield and Prof Britta Regli-von Ungern-Sternberg with Patricia Macchiaverni (second left), the parent of a child with Down Syndrome, who took part in the project.

The most common procedures were gastrointestinal (60.2%) and cardiac surgeries (22.7%). Alongside neonatologist and general surgeons, and more than 250 parents/carers and adults with lived experience of neonatal surgery, the consumer research priorities for this group were finalised. Psychological supports and communication with families, as well as the immediate and long-term physical and neurodevelopmental impacts of neonatal surgery ranked highly.

An ongoing ambitious project is determining the research priorities for children living with chronic pain. The project involves researchers working with nurses, physiotherapists, GPs, pain doctors, OTs and psychologists, as well as children aged from six to 16, young people aged 17-25, parents and clinicians.

> **“Engaging consumers in research is valued by consumers as a recognition of their lived expertise, and as a validation of their insights and experience.**

These consumer-prioritisation projects are an important step in developing meaningful consumer engagement in research. Being engaged in research is valued by consumers as a recognition of their lived expertise, and as a validation of their insights and experience. The consumers themselves have been eager to contribute, and are keen to see how their contributions to our research can make a difference to the future care for Western Australians having anaesthesia and surgery. ■

Parents/Carers

- Perioperative care for children with chronic conditions
- Improvements in care for remote/regional children
- Perioperative experience of children with special needs
- Improving communication with parents

Common Priorities

- Safer anaesthesia for children
- Fear and anxiety
- Pain communication
- Pain at home
- Child-friendly medications

Children and Young People

- Reducing pain after surgery
- Waking up better after surgery
- Postoperative nausea and vomiting
- Safer anaesthesia for children with lung diseases (asthma, sleep problems)
- Mental or emotional health impacts

Anaesthesia and perioperative medicine research priorities of parents/carers, children and young people.

Are we on the right path?

Expedited Pathway raises plenty of questions

Dr David Kingsbury
AMA (WA) Anaesthetics Representative

Our Specialist College system has been the benchmark for many other countries in our region, as they progress towards their own unified national standards for specialist accreditation. The Australian and New Zealand College of Anaesthetists (ANZCA), for example, has played an instrumental role in the development of specialist anaesthesia training systems in Singapore, Malaysia and Hong Kong.

I've worked in the Hong Kong medical system for close to 10 years, and their College system has played a formative role in guiding the development of a national standard for specialist training in Mainland China. We saw first-hand the difficulties faced by the countries in our region that lacked a single strong unified standard – in many of them, specialist training occurs at a multitude of individual hospital, university or provincial-level departments.

This leads to a fragmented specialist accreditation system, with difficulties for doctors wanting to move between hospitals, cities, and internationally; and significant difficulties for patients wanting to identify appropriately trained specialists. Quality of service always inherently falters under these conditions.

A strong opinion within the Australian medical community is that the Expedited Specialist Pathway (ESP) risks fragmenting our world-leading, unified and nationally recognised College-led specialist accreditation system. Instead of Australian hospitals and patients being able to rely on a single identifiable National Fellowship as an indicator of quality training, we will regress to having a multitude of differently trained specialists, registered under the broad and wide-sweeping assurance of 'equivalency'.

The ESP's key driving factor has been to address workforce shortages, with six specialty groups currently chosen: Anaesthesia, General Practice, Psychiatry, Obstetrics and Gynecology, Physician–General Medicine and General Paediatrics. There are many reasons for our current service deficit nationally, but an important contributor is the inadequate number of specialists able to be trained in our public hospitals.

These are our main vehicles for training, and they have been strangled for capacity over the last 25 years. Additionally, some of our smaller specialist Colleges have also been communicating to the Government for some time about their struggle with the financial and human resource requirements to rapidly increase their Specialist International Medical Graduate (SIMG) accreditation pathway numbers. But rather than working within the existing system and assisting these Colleges to achieve this, the decision has been made to create a separate parallel pathway.

Our Specialist Colleges recognise the value that SIMGs bring to the workforce, and the Colleges have developed their own pathways to Australian fellowships for SIMGs. ANZCA has a very robust and efficient system for its SIMG members wanting to attain specialist registration through fellowship, a system which remains more popular with our SIMGs than the ESP. We have not seen evidence that the ESP has been able to allow SIMGs to be registered significantly faster than under the ANZCA pathway. It is difficult to see how the ESP processes can provide the deeply collaborative systems our Colleges currently do, to allow our valuable SIMGs to feel supported and integrated into the wider Australian Specialist community.

Of real concern is the significant risk of creating a perceived second class of Specialists registered under the ESP. Our SIMGs universally speak of the importance of being included in the wider Australian Specialist community, and our Colleges have always benefited from the valuable contribution SIMGs have made to our hospitals and healthcare system overall.

At a time when developing countries around our region are looking to move away from their fragmented Specialist training programs, and towards the Australian College System as their benchmark for a unified national system, these changes risk a significant regressive step for the reputation of Australian healthcare.

We are strongly advocating for the ESP to be a temporary stop-gap measure for increasing required workforce numbers, that should be phased out once there is evidence that the individual Colleges have been able to achieve a comparable capacity and timeframe for accreditation. We would instead like to see initiatives that work with the Colleges, to assist them to expand and enlarge our public health system-based training programs, to achieve our common goal of a safe and accessible medical workforce serving the Australian public. ■