THE AUSTRALIAN NATIONAL UNIVERSITY

HEALTH SYSTEM CHANGES & THE MEDICAL WORKFORCE

Robert Wells

MENZIES CENTRE FOR PUBLIC HEALTH POLICY AND PRACTICE

GLOBALISATION: NO MORE HEALTH SOVEREIGNTY

- Trade:
  - Free trade agreements; economic unions
  - Cover goods & services
  - Medical workforce a global market
- International conventions: e.g. human rights
- Workforce
  - Perceived shortages in most developed countries
  - Reliance on IMGs

ANU

DOMESTIC ECONOMIC FACTORS

- Microeconomic reform: the drive for efficiency through competition
- Balanced budgets/ budget surpluses
- Health costs:
  - Increasing % GDP on health
  - ‘out of control’ items: pharmaceuticals
  - Intergenerational issues
  - Increasing social welfare dependency

ANU

CHANGING HEALTH CARE SCENE

- Greater expectations & demand for services with increasing wealth
- More complex treatment & care needs
- More conditions can be treated
- Patients are better educated & have much greater access to information about their conditions
- Patients investing more out of pocket through higher co-payments, restrictions on subsidised services & for ‘alternative’ therapies

ANU

MORE CHANGE/THREATS ON THE HORIZON

- Growth in obesity & overweight rates among children & adults with will result in significant higher health care costs
- ‘overhang’ issues, e.g. lung cancer in women from high tobacco usage
- The pandemic we will ‘have to have’ will be in addition to normal pressures
- We can expect the ‘technology explosion’ not to subside & follow same pattern: more diagnostics/treatments with additional expenditure
- The ageing riddle

ANU

THE WORKFORCE CONUNDRUM

On the one hand…

- Medical workforce growing faster than population
- Full demand impact of ageing & chronic disease still to come
- Full supply impact of 'baby boomer' retirements still to come

On the other hand…

- Perceived doctor shortages in most categories in most developed countries

ANU

THE FAILURE OF WORKFORCE PLANNING

- Through 1990's perceived actual and projected doctor oversupply
- Since early 2000 perceived actual & growing shortage
- At some point we must have been both over- & undersupplied!
- Governments have obediently followed both trends

➢ Restrictive measures in 1990's

➢ Expansive measures in 2000's

ANU

POLICY RESPONSE: AUSTRALIA AS CASE STUDY

- From 2000: increased medical school & training places; more medical schools
- 2004: National Health Workforce Strategic Framework developed by health ministers
- 2005: Council of Australian Governments (COAG) commissioned Productivity Commission (PC) to review health workforce as part of broader health reform.
- 2005: Australian Medical Workforce Advisory Committee (AMWAC) projected needs for general practice to 2013

ANU

PC FINDINGS

- Workforce supply shortages in several health professions including medicine & in both rural and urban areas
- Pressures will increase with demand, e.g. population ageing
- Need to boost numbers of education and training places
- Need to increase the productivity & effectiveness of available workforce

ANU

PC PROPOSALS

- Establish a national advisory health workforce improvement agency
- Reform education & training arrangements with more flexibility & contestability
- Create national accreditation agency covering all health professions
- Complementary reform of registration arrangements
- Broaden number of professions/services accessible through Medicare Benefits Schedule

ANU

GP WORKFORCE REPORT

- Attempts to understand better the present & future context for General Practice- extensive stakeholder consultations
- Key factors:

- ➢ Increase in demand for services
- ➢ Overall GP shortage (between 800-1300 in 2002) combined with uneven distribution
- ➢ Decrease in hours worked by GPs
- ➢ Ageing GP workforce

ANU

GP REPORT: FINDINGS

- Need to add 1100- 1200 new GPs pa between 2007 & 2013
- This is an increase of 400-500 pa on current intakes
- Recommend a mix of:
  - Additional Australian trainees
  - IMGs
  - Maximising workforce participation of existing GPs
  - New models of care

ANU

ANALYSIS

- Accept the perception as a reality, i.e. there is a workforce shortage
- AMWAC numbers probably a reasonable indicator of the scale of the problem if we do nothing
- We need some fresh approaches to workforce which go beyond the traditional modelling and projections of demand and supply
- The PC & AMWAC reports provide some useful pointers

ANU

WHAT WE NEED TO ACHIEVE

- More efficient us of existing workforce: productivity & flexibility
- More effective integration of IMGs into the workforce
- Training which better equips the workforce for the realities of the work environment

ANU

PRODUCTIVITY & FLEXIBILTY

- Involves job redesign & substitution
- Variations across our countries in what treatments different professions can provide
- Variations in patient outcomes not that great across countries
- Slow & complex process & need to proceed with caution
- If general workforce shortage, substitution a two-edged sword

ANU

INTEGRATION OF IMGs

- Currently exceed 20% of our medical workforces
- Recognise our continuing reliance on IMGs
- Provide better support & more structured entry arrangements
- Policy responses to the ethical issues are required

ANU

MEDICAL EDUCATION & TRAINING

- Continuum: undergraduate-postgraduate-vocational-CPD
- Takes minimum 10 to 15 years to become ‘independent’ practitioner
- Many providers along the way with discontinuities between the various stages

ANU

MEDICAL EDUCATION: SOME PROBLEMS

- Model has not changed a lot in 100years- but health system has changed enormously.
- Trainee doctors seem to spend a lot of time waiting for the next stage.
- Increasingly doctors will be working in multidisciplinary settings but training approach does not seem to reflect this.

MEDICAL EDUCATION SOME QUESTIONS

ANU

- Rethink basic approach: what skills will doctors need at various stages.
- Should we continue with the ‘one size fits all’ approach which seems to be time-based rather than competency-based?
- How much general knowledge do practitioners need if they are predominantly going to work in a highly specialised field?

ANU

MEDICAL EDUCATION: NEW APPROACH

- Introduce possibility of ‘streaming’ during medical school
- Direct early postgraduate years towards meeting requirements for ‘basic’ specialist training
- Identify common areas of training across specialties
- Identify progressive ‘exit’ points in specialist programs which confer capacity for independent practice & allow for further progression (‘skills escalator’)

ANU

CONCLUSION

- Need workforce reform- poor evidence base & hard to reach agreement how to proceed.
- Should move quickly on improving IMG arrangements
- Medical education reform provides the most promise

ANU

READINGS

1. OECD 2005, *Health at a Glance: OECD Indicators 2005.* (www.oecd.org)
2. Productivity Commission 2005, *Australia's Health Workforce,* Position Paper, Canberra (www.pc.gov.au)
3. Australian Medical Workforce Advisory Committee (2005), *The General Practice Workforce in Australia: Supply and Requirements to 2013,* AMWAC Report 2005.2, Sydney (www.healthworkforce.health.nsw.gov.au)