The Royal Australasian
College of Physicians

Response to the Productivity Commission's Health Workforce Study on behalf of The Royal Australasian College of Physicians

July 2005

This submission has been prepared by the Workforce Policy Committee and the Department of Policy and Communications.

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Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the Productivity Commission's study of the health workforce.

The College recognises that it will be some time before the Australian medical workforce is self-sufficient, but wishes to ensure that lack of access to specialist physician and paediatrician care does not disproportionately affect the elderly and those with lower health status, particularly those living in rural and remote areas. However, the levers the College has for influencing health workforce development are limited, being in the areas of education, training, continuing professional development, policy development and demonstration programs.

The College trains physicians and paediatricians in 31 specialties (see appendix 1), indicative of the workforce differentiation which has developed over the past three decades, with the increased diversity in available medical technology requiring not only a range of specific competencies but also associated skill in interpreting the results.

However, with a population that is ageing, and many patients presenting with illnesses affecting more than one organ system or undifferentiated symptoms, the College believes there is a need to train more consultants with the range of skills required to assess and care for these patients. The current imbalance in favour of sub-specialty training primarily affects adult medicine, although similar trends are emerging in the paediatric workforce. It is the major metropolitan hospitals, not the College, that determine the numbers and distribution of trainees. Every dedicated subspecialty position, where there is no possibility of training shared with general medicine trainees, removes flexibility from the deployment of the workforce. Therefore, the balance between dedicated subspecialty training positions and those also supporting maintenance of skills across a broader range of consultant physician/paediatrician practice must be subject to disinterested scrutiny.

The increasing sub-specialisation is a major factor contributing to difficulties in recruitment of physicians to rural and remote areas, where generalist as well as sub-specialist skills are required. However, it is recognised that quality care needs to be provided on a 24 hour basis. While sub-specialist practice may be sustainable in-hours, to sustain a one-in-four after hours and weekend physician roster in all rural and metropolitan areas may require an approach to training so that all physicians feel confident to serve on a general roster.

While the College traditionally does not concern itself with the economics of the profession, this being the province of the Australian Association of Consultant Physicians (AACP), it recognises that remuneration is a major determinant of choice of specialty.

The Medicare Benefits Schedule (MBS), which arose from the reforms initiated by the Nimmo Inquiry Report of 1969, established a set of relativities within the Medical (later Medicare) Benefit Schedule. These have remained relatively unchanged since that time despite advances in technology, so that the cognitive aspects of the consultant's work are

considerably less valued than the procedural aspects. Given that the MBS is a major driver for fees charged by and hence income of the College Fellows, it thus has had a major influence on the way the medical workforce has been distributed both between specialties and geographically.

Two initiatives of the Federal Government in the past decade have had a major effect on the level of physician remuneration within the private sector. The failure of the Relative Value Study (RVS), which meant non-adoption of the College/AACP position in terms of improving the relative value of the consultant physician items against the procedural items in the MBS has meant that certain of the College Fellowship have benefited substantially in comparison with those other Fellows who are more reliant on consultations to generate income. Technology has increasingly improved efficiency in the use of physician time. Throughputs of procedures are proportional to income generated given the open-ended nature of MBS funding (despite the effort of the Australian Government to cap funding by entering *inter alia* five-year funding agreements with both cardiologists and nuclear medicine physicians). Hence the time to undertake a procedural item of physician practice relative to that of cognitive consultative practice has decreased markedly without there being any recognition of this element in the fee for Medicare benefit quantum.

It is important to note that whenever MBS item numbers are introduced or revised, there is a risk of distorting relativities between health practitioners. A more recent example has emerged from the Co-ordinated Care Trials with the enhanced primary care (EPC) items in the MBS, which, with the exception of the limited access for a consultant physician case conferencing item, have been restricted to general practitioners. The item descriptors of the clinical care planning item reflect closely on the descriptors for consultant physician practice, especially with the recent adjustments that separate the development of a management plan from the multidisciplinary team arrangements but also allow substitution of cognitive thinking by both technology and other health professionals. The level of benefits has been struck without any consideration of the relative value so as to almost obliterate the relativity between primary care and consultant practice.

The core business of the College is the training, assessment and continuing professional development of consultant physicians and paediatricians. The College's Education Strategy is moving towards a modular approach to learning based on competencies rather than length of training.[1]

The College believes that increased physician and paediatrician training in non-hospital community settings, rural and outer metropolitan training rotations is necessary in order to provide physicians and paediatricians who can most effectively meet the needs of the Australian population.

[1] Royal Australasian College of Physicians (2005) *Education Strategy, A Work in Progress, 2004 – 2007*. p.6. Available at <www.racp.edu.au/members/edu/RACP_EDU_strategy_April05.pdf> (Accessed 27/08/05)

It also believes that the maintenance of consultant physician training is essential if the physician is not to be considered a technician who employs the technology on demand without the intervening expertise of consultant assessment and opinion. Therefore, the ongoing training of consultant physicians should be directed towards ensuring that the "consultant" element remains constant.

If the aim is to enhance equity in the distribution of the work force across Australia, the likelihood of the outer urban, regional and rural health services each acquiring a "critical mass" of consultant physicians and paediatricians will be enhanced if greater numbers can provide "generalist" specialist services and if there is an increase in the monetary value of the MBS consultation items.

The common practice by which a PhD or MD is effectively a pre-requisite for physicians wishing to hold an academic post or be appointed to a teaching hospital, especially with the growth of rural clinical schools, may prove too onerous. This is not to devalue the value of research, but it is a question of ensuring that the balance between service, training and research is such that there is an equitable distribution of the workforce.

The College recognises that the emergence of both rural scholarship and "area of need" bonded medical graduates may require adjustments in training so that specialist training is undertaken increasingly by doctors located in rural areas who will require urban rotations, rather than the reverse. In fact the two forms of rotation will need to co-exist. Hence, the College will set out to accommodate this new set of graduates from the beginning of 2007; and as such the rural clinical schools will become increasingly important in assuring the appropriate balance between service, training and research.

At the other end of career and the workforce, the College recognises that there will be the extension of professional careers beyond the conventional retirement age; and that it can be reasonably expected that increasing numbers of College Fellows will be working until 75 years of age. Hence their occupational health and maintenance of professional lifestyle will increasingly preoccupy the College, especially where there is a need for augmented continued medical education.

The College believes that good data collection is required to enable governments to provide advice on issues such as future models of care and service delivery, and that such collections should include linkages between health and university databases to monitor the influence of undergraduate initiatives on long-term career choices.

The submission is divided into two sections. Following the Recommendations and Preamble, Section One provides an overview of the physician workforce in Australia, and seeks to address issues that are of concern to College Fellows with regard to the structure and flow of the physician and paediatrician workforce in Australia. Section Two provides an analysis of some of the systemic constraints regarding physician workforce planning.

Recommendations

Balance within Current Medical Workforce

There should be a balanced distribution of the current Australian medical workforce between general practitioners, "generalist" specialists and sub-specialists, between states and territories, and between rural and metropolitan areas, recognising that, at least in the immediate future, there will be shortages in all disciplines of the health workforce.

To achieve this:

- The implications of the ageing population, the associated co-morbidities, the increasing prevalence of chronic illness in both adults and children for models of consultant practice and training of future consultants should be recognised;
- Appropriate triaging between secondary and tertiary care for adults and children referred to consultant physicians and paediatricians should be systematically implemented;
- Efforts of the College to ensure that access to the expertise of adult physicians and paediatricians within and outside of normal working hours is spread across Australia should be supported;
- The current imbalance between numbers of training posts offering only sub-specialist training and those encouraging maintenance of with skills and knowledge to assess and recommend management of adults and children presenting with undifferentiated medical problems and those involving more than a single organ should be rectified;
- Training of consultant physicians and paediatricians should be expanded beyond tertiary hospitals into community and private sector settings to reflect more closely the characteristics of future consultant practice.

Relative Values

The relativities in the Medicare Benefits Schedule should be reviewed in recognition of the influence of the devaluation of the cognitive role of the consultant physician on the distribution of the workforce.

This review should consider:

- The relativity between consultant physician cognitive and procedural items;
- The role of the consultant physician/paediatrician in relation to management plans, team care arrangements, multidisciplinary care plans and case conferences for patients referred from other medical practitioners;
- The relativity with the recently introduced general practice items number 721 to 731 that encompass these services for non-referred patients but also allow substitution by other health professionals to assist in the assessment and identification of patient needs.

Rural Areas

Opportunities should be created for medical graduates from Rural Clinical Schools and bonded scholarship holders to have the opportunity to continue their internship and specialist training from a rural base should they wish to do so.

Further consideration should be given to models of care for remote areas in which the services of consultant physicians and paediatricians are funded through resource pooling as is currently occurring in Coordinated Care Trials.

Preamble

Established in 1938, *The Royal Australasian College of Physicians* is the professional organisation responsible for the training, assessment and on-going professional development of consultant physicians and paediatricians in Australia and New Zealand.

The RACP comprises more than 8,000 Fellows, consisting of Fellows of the Divisions of Adult Medicine and Paediatrics & Child Health, as well as Fellows of the Faculties of Public Health Medicine, Rehabilitation Medicine, and Occupational Medicine and of the Chapters of Palliative Medicine, Addiction Medicine, and Sexual Health Medicine. The Joint Faculty of Intensive Care Medicine is part of both the RACP and the *Australian and New Zealand College of Anaesthetists* (ANZCA). In addition, the RACP encompasses a range of affiliated Specialty Societies representing the spectrum of practice in Internal Medicine and Paediatrics across 31 sub-specialty disciplines.

The core business of the College is the training, assessment and continuing professional development of consultant physicians and paediatricians. Specialist training can commence after completion of the intern year, and Fellowship of the College is gained following successful completion of three years of basic training and three years of advanced training. During advanced training, trainees may pursue a general program or undertake in-depth specialisation in over 20 different areas (e.g. cardiovascular or respiratory medicine). Separate training programs are provided through the Faculties for medical graduates wishing to train in Public Health Medicine, Occupational Medicine and Rehabilitation Medicine.

Consultant physician and paediatric practice involves the comprehensive assessment, diagnosis and management of complex medical conditions in adults or children, based on the interpretation of the findings from the patient's history, physical examination and the results of diagnostic investigations and procedures. Many physicians and paediatricians undertake procedures in relation to a number of sub-specialty areas including cardiac, thoracic, gastrointestinal, neurological and rheumatologic problems.

Consultant physicians and paediatricians see patients only on referral from other medical practitioners, unlike the situation in some other countries where patients can access these specialists directly. The College strongly supports the maintenance of this practice.

SECTION 1

1.1 The College Workforce

The College has surveyed the clinical workforce in internal medicine and paediatrics in Australia and New Zealand every two years for the last 20 years and in recent years has also monitored its rural workforce. The surveys provide information on workforce numbers and population ratios; types of practice; geographical, age and sex distribution; breakdown of specialty; types of activity (e.g. public versus private practice); location of practice; weekly working hours; indigenous workforce and outreach activities. The workforce surveys demonstrate that over the last 24 years the physician and paediatrician workforce has grown in relation to the Australian population (Box 1).

Box 1:

The physician and paediatrician workforce has grown in relation to the Australian population:

- The average annual workforce growth rate from 1981 to 2003 was 3.8% compared with a growth rate of 1.3% per annum in the Australian population over the same period.
- Between 2001 and 2003 the workforce in adult medicine grew by 3.0% per annum whereas the paediatric workforce grew by 2.2% per annum.
- During the same period Australia's total population was projected to grow by only 0.6% while the population aged 0- 14 was projected to decrease.

The surveys show substantial differences between the states and territories in the ratios of consultant physicians and paediatricians to population, both for those practising as generalist specialists and those in sub-specialty areas. The proportion of female Fellows in 2003 was 21%, with the proportions increasing in the younger age groups to 44% of those between 30 and 34 years.[2]

The increase in numbers of adult physicians reflects increased numbers completing sub-specialty training, with only 5% of those gaining Fellowship in 2003 having trained in General Medicine and 6.5% having trained in Geriatrics. For paediatricians who gained Fellowship in 2003, 71% trained in General Paediatrics.[3]

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[2] Dent O (2004) *Clinical Workforce in Internal medicine and Paediatrics in Australia, 2003*. The Royal Australasian College of Physicians. Available at <www.racp.edu.au/hpu/workforce/clinicalsurvey2003.pdf> (Accessed 27/07/05)

[3] Medical Training Review Panel (2004) *8th Report*. Commonwealth of Australia. Available at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-workforceeducation-mtrpcpmec.htm (Accessed 27/07/05)

1.2 Rural and Remote Health Workforce

College records indicate that there are 379 adult physicians (10.5% of total) and 143 paediatricians (14.6% of total) practising in rural Australia. The largest numbers (38% of adult physicians and 27% of paediatricians) are in Darwin, Cairns, Townsville, Launceston, Toowoomba, and on the Sunshine Coast.[4] The proportion of rural physicians aged 60 years and over is 14.8%, and 11.3% of paediatricians.

The 2003 workforce survey shows that 45% of rural adult physicians and 63% of rural paediatricians undertake outreach visits to smaller centres, covering 225 and 126 towns respectively. This compares with 19% of College Fellows overall who undertake rural outreach visits.

The rural areas have become increasingly dependent on overseas-trained physicians. Eighteen of the 24 adult physicians who have been recruited to rural areas in the past eighteen months are overseas trained physicians. It is noted that in July 2005, there were 19 vacant Area of Need positions in rural NSW, with 16 of these positions requiring a general physician or geriatrician.[5]

There are particular problems in the delivery of the services of consultant physicians and paediatricians to remote communities, many of which have large indigenous populations. Consultant physicians or paediatricians are based in a small number of remote locations but there is generally only one, or at best two, in each location. Private practice is not viable in these locations. The roles are regional, with substantial outreach responsibilities and a large consultative and educational component working with Indigenous Health Workers and other primary care clinicians. The College believes that solo practice in these locations is not sustainable, and recommends a minimum of two consultants and an advanced trainee in those areas.

1.3 The Future Workforce

The College does not control the number of trainees, the number of accredited positions in the training program or the distribution of trainees between the various sub-specialties. Each hospital determines the number and nature of trainee positions that it will fund. Trainees are generally selected by the hospital in which they work, although advanced trainees in some sub-specialties are now selected through a state-wide process. NSW and Victoria have moved to consortia-based models of Basic Physician training that will ultimately centralise selection for training in these states. The College accredits positions prospectively following application by the trainee.

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[4] 'Rural' is classified as those categories under zones 3 - 7 of the Rural, Remote and Metropolitan Areas Classification scheme (RRMA). While Darwin (NT) and Townsville (QLD) are not considered rural under this definition, they are included due to isolation by distance.

[5] NSW Health. Area of Need Vacancy List as at 5 July 2005. Available at <www3.health.nsw.gov.au/healthjobs> (Accessed 5/07/05)

The aim of training is to provide the knowledge, skills and attitudes appropriate to future practice as a consultant physician or paediatrician. As there are many different types of possible practice, the training programs need to incorporate a significant flexibility to meet a wide variety of needs. The College has recently developed and is in the process of implementing a comprehensive Education Strategy. The training program is moving towards a modular curriculum, based on achieving competence at each stage. The College seeks support from organisations that employ trainees to ensure these criteria can be achieved during advanced training. Importantly, this strategy also recognises the broader professional and social responsibilities of Consultant Physicians and Paediatricians that underpin the "social contract" between the profession and the Australian population.[6]

In an effort to predict the nature of future practice, the College has commenced rolling cohort studies of paediatric trainees to ascertain the relationship between training programs and eventual practice characteristics. At present it is too early to draw major conclusions from this work, although results to date indicate a preference for sub-specialty practice alone by 36% of advanced trainees, with an additional 46% intending

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[6] The Royal Australasian College of Physicians (2005) *Education Strategy, A Work in Progress, 2004 – 2007*.

According to the principles set out by this document all College training and education programs, for example, must be ensure that:

re: *Skills, Knowledge and Behaviours:*

- Knowledge must be based on the best available information and [scientific] evidence;
- Skills must be appropriate and relevant to the safe and effective practice of medicine;
- Knowledge and skills must be up to date and continually reviewed;
- The determinants of health and their relation to health outcomes must be understood;
- The importance of appropriate attitudes and behaviours must be addressed;
- There should be integrated approach to curriculum development linking basic training to advanced training to CPD.

re: *Professionalism – advocacy, equity of access and ethical practice:*

- The physician must be an advocate for the needs of the patient and more generally on behalf of society;
- The physician must understand the dynamics of partnerships with health consumers and other health professionals;
- The practice of the physician must be ethical and respect the wishes and best interests of the patient;
- Equitable patient access to the knowledge and skills of the physician must be provided;
- Trainees and physicians should be familiar with, and able to access, the range of opportunities provided by the College;
- The trainee and physician should be culturally aware;
- The physicians and trainees should be aware of current policies which impact on their practice;
- The educational programs should be informed by relevant policy decisions.

to practice with both sub-specialty and general responsibilities. In addition 51% indicated a preference for a salaried teaching hospital position.[7]

As noted in the Annual Reports of the Medical Training Review Panel, while the numbers of graduates from Australian medical schools has remained relatively constant at less than 1,300 over the period between 1997 and 2005, the number of first year positions available for advanced training for medical graduates has increased by 30% with an estimate of 1,782 positions available for 2005. The number of first year advanced training positions for Adult Medicine trainees increased by at least 73.6% between 1997 and 2004 (trainees in joint programs with other Colleges were excluded from these figures), and for Paediatrics by 64.4%.[8]

Some of these increases were in line with recommendations from AMWAC reviews of paediatrics and a number of adult medicine sub-specialties, although in most sub-specialties the increase exceeds the recommendations.[9]

General medicine trainees comprised 6.2% of advanced adult medicine trainees and 9% of geriatric trainees. General paediatric trainees comprised 58% of all advanced paediatric trainees.

Females now comprise 40% of adult medicine and 63% of paediatric trainees.

The AMWAC report on *Career Decision Making* reported that 26% of adult medicine and 29% of paediatric trainees in 2002 intended to work overseas within the following three years, and that 25% of adult medicine and 27% of paediatric trainees intended to do a higher degree in the following three years. [10] The College supports involvement of its Fellows in the research and academic contributions to health improvement.

The College recognises that these statistics, together with the fact that many females may work reduced hours for family reasons in the years immediately after gaining Fellowship, have implications for the consultant physician and paediatrician workforce in the immediate future. Furthermore, the same AMC Report indicated that about a quarter of current advanced trainees intend to be working less than 40 hours per week within five years, which suggests that there are new trends in planned work/life balance for both males and females that will impact significantly on both training and workforce.

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[7] Summary Report on the Descriptive Data derived from the Paediatric Cohort Surveys 1998/9-2001. Directorate of Education, RACP

[8] Medical Training Review Panel (2004) *8th Report*.

[9] Australian Medical Workforce Advisory Committee (2004) *AMWAC Workforce Reviews – Summary of implementation of recommendations – 2004*. Available at <www.health.nsw.gov.au/amwac/pdf/impamwac_2004.pdf> (Accessed 27/07/05)

[10] Australian Medical Workforce Advisory Committee (2003) *Career Decision Making By Doctors In Vocational Training: Proceedings of the Workshop Held to Consider the Findings of the AMWAC Medical Careers Survey 2002 and Possible Future Directions For Vocational Medical Training.* AMWAC Occasional Paper, Sydney

There is limited evidence, especially for adult physicians, regarding the preference for salaried positions compared with fully private practice. Anecdotal evidence suggests that there may be a preference for salaried positions with right of private practice rather than establishing independent private practices, with the associated expense and responsibilities. The majority of consultant physician and paediatrician appointments in metropolitan teaching hospitals are now salaried with right of private practice. In contrast, there are few salaried specialist positions in rural hospitals. The need to manage a private practice is likely to be a further disincentive to rural practice for recently qualified specialists, particularly as the demands on time increase with teaching students from the rural clinical schools.

1.4 Workforce of the Faculties

In comparison with the adult physicians and paediatricians, the numbers of active Fellows in the Faculties are relatively small. Within Australia, the Faculty of Public Health Medicine has 452 active Fellows, Occupational Medicine has 235 and Rehabilitation Medicine has 263.

In 2003, six new Fellows were admitted to Public Health Medicine (a fall of 5% since 2000), four to Occupational Medicine, (a rise of 1% since 2000), and twelve to Rehabilitation Medicine (a fall of 1% since 2000).[11]

There are currently 71 trainees in Public Health Medicine. There is however a limited number of publicly funded training positions which makes employment very competitive. This contrasts with the situation in New Zealand where there is a national publicly funded training program with positions in each District Health Board. This issue needs to be addressed in Australia in view of the need for Public Health physicians in disease prevention and control programs as well as the need to respond to global health threats such as SARS and Avian Influenza.

There are currently 105 active trainees in Occupational Medicine in Australia. As there are no publicly funded positions, trainees must identify a work situation in which training can occur and apply to the Faculty for accreditation of their training program.

The available number of first year training positions in Rehabilitation Medicine increased from 13 to 29 between 1997 and 2004. There are currently 111 trainees in the program in Australia. As for other clinical services, the decline in outpatient services in hospitals means that trainees may be less exposed to ambulatory patient care. The Faculty of Rehabilitation Medicine is developing linkages with private and community-based settings for training purposes. Aware that increasing caseload and greater patient acuity in hospital environments may prevent trainees and Fellows from fully participating in formal teaching or educational activities, the Faculty is seeking to ensure that adequate supervision, educational opportunity and living conditions are in place for trainees and that trainees are withdrawn where such conditions are not provided.

[11]Medical Training Review Panel (2004) *8th Report*.

Direct support of training by government by attaching the funding to the trainee, with the Colleges still determining whether the environment and experience was appropriate for training, rather than funding a training position, would enable greater use of community training and training in a wider range of environments.

In the specialties covered by the Faculties, modern multidisciplinary models of care require team-based communication skills and collaborative decision-making, and inclusion of such themes in the curriculum is an essential part of training. Public Health Physicians and, to a lesser extent, Occupational Physicians, deal with issues affecting the health of populations or sub-groups of a population although increasingly are playing a role as consultants in environmental medicine.

Lack of exposure to these disciplines during the early post-graduate years, spent largely in tertiary hospitals, limits the awareness and understanding of these forms of medical practice by young graduates making career choices.

1.5 The Changing Environment

A number of changes in the environment in which health care is delivered impact on the quantity and nature of services the health workforce is required to deliver.

1.5.1 The Ageing Population

The effect of the ageing population on the demand for health services is well documented, as are other issues such as advances in technology, increased consumer expectations, the growth of the private hospital sector, reduced working hours, and the global nature of the health workforce.

Between 1998-99 and 2003-04, the number of hospital admissions for Australians aged 75 years and over increased by 37%. In 2003-04, 70% of admissions to public hospitals were acute medical admissions or for medical procedures.[12]

Co-morbidity, or the existence of more than one long-term medical condition, is highly correlated with age, rising to 96% among those aged 75 years and over.[13] Many patients presenting with surgical conditions also suffer from medical conditions that require stabilisation and monitoring during the peri-operative period.

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[12] Department of Health and Ageing (2005) *The State of Our Public Hospitals. June 2005 report.* Commonwealth of Australia. Available at <www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-ahca-sooph-index05.htm> (Accessed 27/07/05)

[13] Australian Institute of Health and Welfare (2004). *Australia's Health 2004*. Canberra: AIHW. Available at < www.aihw.gov.au/publications/aus/ah04/ah04-c00-040804.pdf> (Accessed 27/07/05)

1.5.2 Chronic Illness

It is recognised that Australia's overall burden of disease will be increasingly dominated by chronic conditions[14,15]. The effective management of chronic disease requires long term treatment and monitoring of multiple co-morbidities by a multidisciplinary team in a community setting.[16, 17] Consultant physicians and paediatricians play a vital role in these teams as both consultants to primary care practitioners and as treating clinicians for more complex cases.[18, 19]

1.5.3 Child Health

In relation to paediatric practice the need for neonatal paediatricians has increased, although perinatal mortality has fallen, and there are many children living today with chronic illness and disability. There has been a growth in childhood morbidity associated with a range of behavioural and developmental problems, leading to a greater concentration in paediatric training and practice on early childhood development. Management of these problems is multidisciplinary but requires the continued involvement of consultant paediatricians, predominantly in a community -based ambulatory care rather than an in-patient setting.

1.5.4 Benefits of Prevention and Health Promotion

The contribution of primary prevention and early detection of disease to the health of the population is increasingly recognised.[20] Fellows of the Faculty of Public Health Medicine make a substantial contribution in this area.

1.5.5 Fear of Litigation

Increasing fear of litigation has influenced the practice of all medical practitioners, leading to an increased dependence on technology in both diagnostic and therapeutic procedures for medico-legal rather than strictly clinical reasons.

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[14] Australian Institute of Health and Welfare (2002). *Chronic diseases and associated risk factors in Australia, 2001*. Canberra: AIHW. Available at <www.aihw.gov.au/publications/phe/cdarfa01/cdarfa01-c00.pdf> (Accessed 27/07/05)

[15] Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Australian Institute of Health and Welfare. Canberra: AIHW, 1999.

[16] Bodenheimer T. Wagner EH. Grumbach K. (2002) Improving primary care for patients with chronic illness. *JAMA*. 288(14):1775-9.

[17] Von Korff M. Tiemens B. (1997) Individualized stepped care of chronic illness. *Western Journal of Medicine*. 172(2):133-7

[18] Katon W. Von Korff M. Lin E. Simon G. (2001) Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. *General Hospital Psychiatry*. 23(3):138-44.

[19] Gask L. (2005) Role of specialists in common chronic diseases. *BMJ.* 330(7492):651-3.

[20] Wanless D (2002) *Securing our Future Health: Taking a Long Term View*. *Final Report*. H-M Treasury UK. Available at <http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm> (Available 27/07/05)

1.5.6 Occupational Health and Safety

The health of the health workforce has an influence on productivity.

Specific Occupational Health and Safety issues that are investigated and managed by Fellows of the Faculty of Occupational Medicine and that need to be considered in the health workforce include:

- Manual handling issues
- Infectious disease transmission
- Fatigue management – including long hours, lack of holidays, and night shift/rotating shifts
- Chemical or Radiation exposure
- Violence and aggression in the work-place
- Drugs of addiction
- Depression
- Ageing of the health workforce.

The impact of ageing of the health workforce was reviewed in a recent study.[21] This indicated that 23% of the active specialist workforce in 2001 was born before 1946 and a decline in the proportion of specialists working 41 or more hours per week between 1986 and 2001. The study recommended policies and incentives, including attention to occupational health and safety issues, to encourage ongoing employment, albeit at reduced hours, among older clinicians.

1.6 Implications for the RACP and its training programs

The College believes that the workforce data, together with the changing demographic profile of the population, indicate that the balance between the numbers trained and intending to practise solely in a sub-specialty, and those trained to assess and care for patients presenting with complex multi-system and undifferentiated medical conditions has moved too far in the direction of sub-specialty practice. Although this imbalance is most acute in the adult medicine workforce, similar trends are emerging in the paediatric workforce. The situation reflects, *inter alia*, the demand for sub-specialty trainees in the major metropolitan hospitals and the fact that many of these hospitals, particularly in NSW, no longer have general medicine units.

This sub-specialisation has contributed to increasing difficulties in recruitment of consultant physicians and paediatricians to rural, remote and outer metropolitan areas, where "generalist" specialist skills are required. In turn, this has resulted in a disproportionate dependence on overseas trained physicians in rural areas, where support is limited.

The College recognises the substantial improvements in health outcomes that have followed advances in knowledge and technology in the sub-specialty areas of practice,

[21] Schofield DJ. Beard JR. (2005) Baby boomer doctors and nurses: demographic change and transitions to retirement**.** *Medical Journal of Australia*. 183(2):80-3.

and accepts the evidence of the effectiveness and efficiency of treating certain acute medical cases within specialist units such as coronary care, gastro-intestinal bleeding and stroke units. However, it believes that appropriate triage is required to ensure that patients with the greatest need for sub-specialist tertiary care can access this care without undue delay, and that patients with multiple medical conditions requiring secondary rather than tertiary level care, are not referred to a number of sub-specialists if assessment by a "generalist" specialist would be able to provide appropriate care.

The recent review of health services in Western Australia identified a "substantial emphasis on tertiary hospital care to the detriment of secondary hospitals and population based approaches" and reported that "about 80% of admissions to Perth's tertiary hospitals are for secondary type services and general hospital care."[22] The College understands that many officers in other State Health Departments are also concerned that there are insufficient numbers of adult physicians able to contribute to general consultant physician duties outside their sub-specialty area. With current concerns about safe hours, and the general view that sustainable practice requires an after-hours roster of no more than one in four, the College believes that not only rural hospitals but also outer metropolitan and inner metropolitan district hospitals will have difficulty maintaining high quality physician services across at least 15 sub-specialties.

It is of interest to note that in New Zealand, where workforce problems are similar to those in Australia, a proportion of trainees attain Fellowship with competencies in both General Medicine and a sub-specialty as this increases their employment prospects.[23]

Two recent Australian Studies have examined the characteristics, presenting problems and some outcomes of patients admitted to hospital with acute medical problems, and have shown the co-morbidities and ageing nature of that population.

The study of 1,294 consecutive admissions to a General Medical Unit in a 500 bed metropolitan hospital [24] showed that 18 conditions comprised 88% of presentations, spanning all major specialties except for rheumatology. Forty-nine per cent of patients were aged over 70 years, and 31% were aged 80 or older. The average number of diseases per patient was 4.8.

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[22] Department of Health, Western Australia (2004) *A Healthy Future for Western Australians. Report of the Health Reform Committee.* Available at <www.health.wa.gov.au/hrc/finalreport/index.cfm> (Accessed 27/07/05)

[23] New Zealand Health Workforce Advisory Committee. (2005) *Fit for purpose and for practice. A review of the medical workforce in New Zealand. Consultation Document*. Available at <www.hwac.govt.nz/publications/fitforpurpose.htm> (Accessed 27/07/05)

[24] Kingston M. (2005) Determining the professional attributes of a hospitalist: experience in one Australian metropolitan hospital. *Internal Medicine Journal* 35 (5), 305-308.

A Medical Inpatient Study conducted at five hospitals in metropolitan Melbourne in 2000 concluded that:

> "The provision of clinical services in Specialist Medical Units did not lead to better length of stay outcomes for patients with complex medical conditions including impaired cognition and other social factors, than management by General Medical Units did. Socio-economic factors and the differential availability of sub-acute services and both formal and informal community-based residential care complicated the identification of differences in performance between hospitals." [25]

Researchers at John's Hopkins University recently reviewed mortality data from 1996-2000 for 3,075 United States counties and found that, whilst higher primary care doctor to population ratios served to lower mortality rates, the opposite was the case for consultant specialist physicians. The authors speculated that such results were due to higher patient exposure to unnecessary tests and procedures under consultant specialist care, and that this led to a higher incidence of adverse events. Speciality care (with a single organ system focus) also tends to fragment medical care, increase costs and exacerbate health care disparities when compared to primary and other generalist based care.[26]

[25] Nosworthy J. Campbell D. Byrnes G. Staley C. (2001) *Medical Inpatient Study Report*. Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health.

[26] Starfield B. Shi L. Grover A. Macinko J. (2005) The Effects Of Specialist Supply On Populations' Health: Assessing The Evidence. *Health Affairs*, [March 15 Web Exclusive]

SECTION 2

2.1 What is the RACP's role in workforce planning in Australia?

By its commitment to review on an ongoing basis its training and education programs, the College will continue to produce consultant physicians and paediatricians who are recognised internationally to be of a highest standard, both technically and professionally. Nonetheless, whilst the College (and the profession) can work diligently to maintain professional standards and competencies, its ability to shape the health workforce (including numbers, skill-mix or balance, and distribution) beyond this is limited.

Indeed, the principal policy "levers" to influence specialist workforce flows are to be found in the financing structures of the health system, and in the governing bodies and organisations that administer them. *Box 2* illustrates this point by addressing the question of increasing the ratio of Consultant General Physicians to Consultant Specialty Physicians in the workforce to meet the future healthcare needs of the population.

Box 2	
***Problem*:** The ratio of Consultant General Physicians to Consultant Specialty Physicians has declined over the past 20 years.	
Question: How do we increase the ratio of Consultant General Physicians to Consultant Specialty Physicians in the workforce to meet the future healthcare needs of the Australian population?	
Policy Levers	***Who***
Purchasers of Services need to recognise and value the role of general medicine within the context of service delivery and ensure that (1) sufficient number of training positions in general medicine are funded in both hospital and community settings; and (2) positions within the public health system for Consultant General Physicians are funded and that general medicine is made attractive as a career choice.	**State and Territory Governments** **Area Health Services and hospitals.**
The Medicare Benefits Schedule must reflect (1) the 'value' of the general consultation relative to that of procedural medicine; and (2) the 'value' of the Consultant General Physician in planning and coordinating health care in chronic and complex conditions.	**Commonwealth Government and HIC**
Senior physicians must recognise the value of, general medicine and encourage junior doctors to pursue a training program and career in this area.	**RACP Fellowship**

2.2. Consideration of structural constraints to rational health workforce planning

Health care markets, more than most, are characterised in all countries by a high degree of "market failure", a phenomenon long described in the literature.[27] Most governments of developed countries clearly recognise the dangers that such "market failure" in the delivery of healthcare services pose to the public interest and act to ameliorate any adverse effects through public intervention and regulation.

Australia provides a tax-funded, universal healthcare coverage to its citizens. Decisions about total expenditures, prices and types of service are made by government bodies in negotiation with a myriad of professional associations and representative groups. The resulting system guarantees a minimum level of access to affordable care for all, providing for free public hospital use (AHCAs) as well as heavily subsidised ambulatory medical care (Medicare) and pharmaceuticals (Pharmaceutical Benefits Scheme). It is a classic example of government regulation in the name of the public interest, and by and large this interventionist approach has been successful. The health of Australians continues to improve, and the Australian health care system compares favourably with other OECD countries on most performance measures: including health production[28], technical efficiency[29], and equity of access[30]. On all measures it performs better than those underpinned predominantly by the operation of the market (e.g. United States of America.)

The high degree of public intervention and regulation, however, has produced a series of side-effects that present policy-makers with challenges. One of these is the insulation of the health labour market from the classical mechanisms of matching workforce supply with expressed demand. In lieu of market forces producing equilibrium, other approaches to ensure that workforce supply meets the labour demands of health system over time have to be introduced to counter cyclic imbalances in workforce number, composition and distribution.[31] Explicit workforce planning is increasingly recognised as one of the

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[27] Hall J. & van Gool K. (2001) Market forces: An examination of the Australian health care market and its impact on the medical workforce, in *Papers of the 5th International Medical Workforce Conference* November 2000, ed. Australian Medical Workforce Advisory Committee, Sydney. Available: http://www.healthworkforce.health.nsw.gov.au/

[28] Or Z. Wang J. Jamison D. (2005) International differences in the impact of doctors on health: a multilevel analysis of OECD countries. *Journal of Health Economics*. 24(3):531-60.

[29] Retzlaff-Roberts D. Chang CF. Rubin RM. (2004) Technical efficiency in the use of health care resources: a comparison of OECD countries. *Health Policy.* 69(1):55-72.

[30] van Doorslaer E. Masseria C. & the OECD Health Equity Research Group Members (2004) *Income-Related Inequality in the Use of Medical Care in 21 OECD Countries*. OECD Health Working Paper N° 14. DELSA/ELSA/WD/HEA (2004)5.

[31] Australia's health workforce problems are similar to those experienced by comparable health systems around the world. A recent WHO technical report suggested that such imbalances can fruitfully be understood across 5 dimensions: (1) profession/specialty imbalance; (2) geographical imbalance; (3) institutional and services imbalance; (4) public/private imbalance; and (5) gender imbalance. See WHO

options being adopted by countries to deal with these imbalances, although few if any to this date have hit on a successful approach.

A recent policy paper commissioned by the Canadian Government compared the planning approaches of five countries with predominantly publicly financed health systems (Australia, France, Germany, Sweden, and the United Kingdom). The authors concluded that planning across all countries was characterised by "policy conservatism, with little if any appreciation and application of economic analysis and tools".[32]

In the Australian context there are several structural and system-level barriers that need to be addressed to allow for a more coherent and rational understanding of workforce planning to develop. These include:

(a) Limited consideration of incentives and disincentives produced by the financing structures of the health system in the attracting, training, recruiting and retention of health professionals

Outside of the health economics literature, little attention is paid to how existing financial incentives and disincentives shape workforce flows within a highly regulated market. Recent longitudinal research, for example, identified income alone - as established by fee-for-service schedules - as the most important determinant of Canadian physicians' specialty choice (both the decision to specialise and the choice among specialties.)[33] Such research has important implications for identifying the policy "levers" that exist for producing an appropriate health workforce over time, especially within a market insulated from the market forces of supply and demand and dominated by negotiations between governments and professional organisations.

In the Australian context there are numerous perverse incentives produced by the financing structure of the health system that shape the medical workforce. These operate at both the Commonwealth and State levels. Of particular relevance to the College are those incentives within (i) the Medicare Benefits Schedule (MBS) and (ii) the States' funding of hospital positions, both of which promote the growing trend toward specialisation at the expense of general internal medicine.

(2002) *Technical consultation on imbalances in the health workforce.* World Health Organization 2002. Available at www.who.int/hrh/documents/en/consultation_imbalances.pdf

[32] Bloor K. Maynard A. (2003) Planning human resources in health care: Towards an economic approach – An international comparative review. Canadian Health Services Research Foundation. Report commissioned by the Canadian Health Services Research Foundation. Available: www.chsrf.ca/final_research/commissioned_research/programs/pdf/bloor_report.pdf

[33] Gagne R, Leger PT. (2005) Determinants of physicians' decisions to specialize. *Health Economics*. 14 (7):721-35. This study is particularly interesting because its methodology does not rely on self-reported data collected from surveys – a more standard approach to addressing this question. Instead, the authors look at how closely trends of choice of speciality over a 30 year period aligned with shifts in the fee-for-service schedule thus treating income as an exogenous variable. Objections to the applicability of this study to the Australian environment, citing the very high levels of student debt accrued by Canadian medical students, can be countered by the emerging trend in Australia towards full-fee paying students and significantly higher co-contributions to publicly funded university places.

(i) The Medicare Benefits Schedule

This is a major driver for fees charged by and hence income of the College Fellows, and thus, while not the only influence has a major influence on the way the medical workforce has been distributed.

While the College traditionally does not concern itself with the economics of the profession, this being the province of the Australian Association of Consultant Physicians (AACP), it should be noted that the Medicare Benefits Schedule which arose from the reforms initiated by the Nimmo Inquiry Report 1969, established a set of relativities within the Medical (later Medicare) Benefit Schedule (MBS). Until recently, these relativities have remained intact with a number of exceptions despite advances in technology.

The College and the Australian Association of Consultant Physicians undertook a considerable amount of work in the mid to late 1990s in relation to the Relative Value Study.[34] One of the pressures for this reassessment of the Medicare Benefits Schedule related to concern that the relativities determined in the early 1970s were unfavourable to those with a high consultative work base and a low diagnostic or procedural base. Consultant physicians and paediatricians are in this category.

Non-adoption of the College/AACP position in terms of improving the relative value of the consultant physician items against the procedural items in the MBS has meant that some of the College Fellowship have benefited substantially in comparison to those other Fellows who are more reliant on consultations to generate income. Technology has increasingly improved efficiency in the use of physician time. Throughput of procedures is proportional to income generated given the open-ended nature of MBS funding (despite the effort of the Australian Government to cap funding by entering *inter alia* five-year funding agreements with both cardiologists and nuclear medicine physicians). Hence the time to undertake a procedural item of physician practice relative to that of consultative practice has decreased markedly without there being any recognition of this element in the fee for Medicare benefit quantum.

Concerns about the relativity of the benefit for cognitive practice and that for procedural and technical activities remain. This relativity is seen as an important incentive to practise in a sub-specialty with a substantial procedural and technical component. The extent to which these incentives will be enhanced remains to be seen as more doctors graduate with substantial debts arising from HECS or as full fee-paying students.

It is important to note that whenever MBS item numbers are introduced or revised, there is a risk of distorting relativities between health practitioners. A more recent example has emerged from the Co-ordinated Care Trials with the Enhanced Primary Care (EPC) items

[34] The Relative Values Study. (2000). Available at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-rvs-rvsstudies

in the MBS, which, with the exception of the limited access for a consultant physician case conferencing item, have been restricted to general practitioners. The fact that these consultant physician case conference items have been underutilised reflects the discord between the current item requirements and actual multidisciplinary consultant practice.

The descriptors for the recently introduced general practice items number 721 to 731 in relation to management plans, team care arrangements, multidisciplinary care plans and case conferences reflect closely on the descriptors for consultant physician practice. The level of benefits has been struck without any consideration of the relative value so as to obliterate the relativity between primary care and consultant practice. It thus ignores the importance of multidisciplinary care in many areas of consultant practice and the fact that the referral of the patient to the consultant physician by another medical practitioner for reasons of complexity of diagnosis and/or management distinguishes the practice of the consultant physician from that of the primary care practitioner. The fact that the items allow a practice nurse or other health professional, as well as the use of computerised care plans, to partly substitute for the medical practitioner's role in the patient assessment and identification of patient needs further alters the relativities.

The maintenance of consultant physician training is essential if the physician is not to be considered a technician, who employs the technology on demand without the intervening expertise of consultant assessment and opinion. Therefore, the ongoing training of consultant physicians should be directed towards ensuring that the "consultant" element remains constant.

The relationships between the relativities of the benefits, the nature of practice of the tertiary hospital and academic role models, and the perceived prestige of the practice cannot be quantified, but there seems little doubt that the perceived prestige of sub-specialty practice in a tertiary hospital influences career choice.

AFOM and AFPHM Fellows are particularly involved in decision making affecting more than one individual. The lack of recognition by the HIC of the contribution of these Fellows to communities of interest in areas as diverse as environmental, indigenous and occupational groups contributes to difficulties in training. Recognition of these two specialties as consultants in the environmental health area would provide better health outcomes and service the growing community concerns regarding environmental affects on health.

(ii) States' Funding of Hospital Positions

The traditional tertiary teaching hospital environment remains the location for most medical training. Undergraduates and specialist trainees (with the exception of general practice registrars) are thus primarily exposed to this tertiary care environment in which their supervisors, mentors and role models practice. The positions funded, their speciality focus and their distribution are directly determined by the employing hospitals. Advanced General Medicine trainees have limited opportunities to experience sub-specialty training as the majority of training positions in sub-specialty units are restricted to sub-specialty trainees. However, the reverse may be true in some areas of paediatrics,

where training in small sub-specialties such as paediatric neurology may be unsustainable unless dedicated training posts are maintained.

Despite recognition of the importance of chronic disease management in the community setting, there is limited exposure to physician and paediatrician practice outside the hospital environment, and with the reduction in numbers of public hospital outpatients, frequently a limited exposure to ambulatory care. The College supports recent initiatives that are considering the feasibility of training in community settings and in the private sector that more closely mirror the environment in which many will eventually practice and the health problems they will be required to manage.

The College strongly supports rural and outer metropolitan rotations during training for basic trainees in both adult medicine and paediatrics to ensure that trainees gain exposure to a broader range of medical conditions and experience more limited access to diagnostic facilities and sub-specialist advice. However, many hospitals in these locations do not see the volume of patients required nor have available on site supervision for appropriate advanced training in a sub-specialty. Advanced training positions in these rural and outer metropolitan hospitals are difficult to fill when the number of positions available in teaching hospitals exceeds the number of potential applicants. In addition, the supportive training infrastructure in many of these hospitals is less than that available in the tertiary hospitals. There is more limited access to the IT resources available in tertiary hospitals, there is less research and there are fewer salaried physicians and paediatricians. Teaching and supervision thus imposes an additional burden on the visiting consultants. Links between metropolitan and rural hospitals both through joint appointments of consultant staff and through videoconference access to training and professional development activities can assist in reducing the professional isolation for both trainees and consultants.

Some of these issues are progressively being addressed through the Rural Clinical Schools and University Departments of Rural Health. The College believes it is important that medical graduates from these schools as well as rural scholarship and "bonded" graduates have the opportunity to continue their internship and specialist training from a rural base should they wish to do so. Thus adjustments in training will be required so that specialist training is undertaken increasingly by doctors located in rural areas who will require urban rotations as well as the reverse.

The College believes that all trainees, irrespective of the sub-specialty in which they trained, should have maintained their skills as a general physician at the time of gaining Fellowship. However it recognises that this is difficult in the tertiary hospital environment where hospitals do not require sub-specialty registrars to continue a role outside their specialty.

(b) The absence of a set of dynamic and stochastic modelling tools to underpin planning processes

Current modelling tools used to guide decision making to address future workforce needs tend to be deterministic and static - with little or no capacity to anticipate changes in key determinants. "Ideal" workforce numbers are typically based on historical doctor to population ratios or utilisation rates with little consideration given to examining the relationship between:

1) models of care and service delivery[35];
2) type, skill-mix , number and distribution of health professionals required to staff such service delivery models; *and*
3) health outcomes expected from service implementation (health production)

AMWAC, for example, uses a simple "stock and flow" model to generate predictions on future workforce imbalances within the specialist medical workforce. The utility of its current recommendations rests ultimately on simplistic assumptions that workforce needs can be modelled by matching the projected population health needs of Australia with current service utilisation rates.[36] Despite this, the College is encouraged by AMWAC's own admission that it needs to move towards a "models of care" approach to workforce planning:

> "as a broader information base on health outcomes and quality practices becomes available, ***it should be possible to link outcomes and quality to ideal models of care which can then guide health service provision and as part of this workforce planning and workplace organisation.*** In turn, this should ensure that workforce planning is better integrated into broader health system planning covering models of care and service delivery developments. This approach should be viewed as an important goal to work towards." [37]

The College wishes to work with governments to ensure that the training and education program produces physicians and paediatricians that serve the populace within the context of the Australian health system(s) and its financing structures. The modelling tools and data collections are currently lacking that will enable governments to provide advice on issues such as future models of care and service delivery.

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[35] For example. Chronic illness care (multidisciplinary, long-term, community setting) vs. acute care (episodic, hospital/clinic setting). There needs to be comprehensive rethink as to how we deliver services to rural and remote areas. The current "model" (eg transplantation of urban model – specialist staff hospitals within AHS, ambulatory GPs etc has not worked) despite repeated attempts to provide incentives to attract health workers.

[36] Australian Medical Workforce Advisory Committee (2003) *Specialist Medical Workforce Planning In Australia: A guide to the planning process used by the Australian Medical Workforce Advisory Committee.* Available: <www.health.nsw.gov.au/amwac/ pdf/spec_med_work_plan2003.1.pdf> esp. pp.46-54 (Accessed 27/07/05)

[37] Australian Medical Workforce Advisory Committee (2003) Specialist Medical Workforce Planning In Australia: p.49.

(c) Lack of system-wide planning

Most planning currently takes place within narrow professional silos, with little modelling of future needs as to the right balance of professions and skill-mix within service delivery models that have been shown to improve health outcomes. AMWAC, for example, is concerned solely with the medical workforce, which is kept separate from any other planning of the broader health workforce; and indeed, no planning of the health administration workforce occurs at all. This "silo-based' planning is particularly distorting in a regulated market that is characterised by a high degree of regulatory capture. [38]

Failure to get the balance right even *within* professional silos (e.g. primary health care doctors versus consultant specialists, and Consultant General Physicians versus Consultant Specialty Physicians) can have serious implications for the quality of care delivered to the populace. Researchers at John's Hopkins University, for example, recently reviewed mortality data from 1996-2000 for 3,075 United States counties and found that, whilst higher primary care doctor to population ratios served to lower mortality rates, the opposite was the case for consultant specialist physicians. The authors speculated that such results were due to higher patient exposure to unnecessary tests and procedures under consultant specialist care, and that this led to a higher incidence of adverse events. Specialist care (with a single organ system focus) also tends to fragment medical care, increase costs and exacerbate health care disparities when compared to primary and other generalist based care.[39]

The challenge for policy makers is to get the right balance *between* primary care, consultant general physicians and consultant sub-specialty physicians, as much as it is to get the right numbers.[40, 41, 42] And furthermore to ensure that the service delivery models reflect the balance required to meet the actual health needs of the population.

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[38] Regulatory capture emphasises the influence of interest groups in he formation and maintenance of public. Articulated most famously by the Nobel Laureate George Stigler, the theory assumes that regulatory agencies are subject to pressure and influence by the very groups that are the subject of regulation, and who seek to protect their own interests. Over time, such groups becomes so adept at such "rent seeking" behaviour that private interests come to be better served by regulatory regimes than the public interest for which the regulations were designed to protect in the first place. In the context of the Australian health are system, a multiplicity of historically prominent professional groups with vested (and often narrow) interests have long dominated the political and healthcare policy decision landscape, acting principally to protect the professional standing and incomes of their membership.

A useful discussion of regulatory capture with relevance to the medical professions can be found in: Maks J. A. H. & Philipsen, N. J. (2002) An Economic Analysis of the Regulation of Professions, in *The Regulation of Architects*. Antwerpen, Intersentia. Available www.fdewb.unimaas.nl/eurecom/professionalregul.pdf

[39] Starfield B. Shi L. Grover A. Macinko J. (2005) The Effects Of Specialist Supply On Populations' Health: Assessing The Evidence. *Health Affairs*, [March 15 Web Exclusive]

[40] Willison DJ. Soumerai SB. McLaughlin TJ. Gurwitz JH. Gao X. Guadagnoli E. Pearson S. Hauptman P. McLaughlin B. (1998) Consultation between cardiologists and generalists in the management of acute myocardial infarction: implications for quality of care. *Archives of Internal Medicine.* 158(16):1778-83.

2.3. The Way Forward

The College recognises that, at least in the immediate future, there will be shortages in all disciplines of the health workforce. This submission focuses mainly on consultant physicians and paediatricians, but workforce issues affecting the faculties of the College also need to be recognised.

The College recognises that it will be some time before the Australian medical workforce is self-sufficient and is thus playing a substantial and increasing role in the assessment of overseas trained physicians, and is paying greater attention to recognition of prior learning in these situations. However, it believes that there should be a balanced distribution of the current Australian medical workforce between general practitioners, "generalist" specialists and sub-specialists, between states and territories, and between rural and metropolitan areas. The College wishes to work with governments to ensure that the lack of access to specialist physician and paediatrician care does not disproportionately affect the elderly and those with lower health status, particularly those living in rural and remote areas.

The College believes that better triaging of patients requiring secondary and tertiary care will be beneficial to the health system and to many patients, particularly the elderly and those with multiple morbidities. This will require a change in the current balance between "generalist" specialists and sub-specialists, and thus a change in the staffing and admitting procedures of some hospitals.

The College acknowledges that the "generalist" specialist of the 21st century will need to be different from that of the past, and that there is a need for flexibility in training to allow the health needs of different locations to be met. The "generalist" specialist may be:

- A physician or paediatrician trained in General Medicine or Paediatrics who maintains skills and knowledge across part of the breadth of consultant practice, realising that the information explosion means that no person can stay broadly skilled across the entirety of adult medicine or paediatrics. Some may have skills or an interest in one or several sub-specialties.
- A physician trained in a sub-specialty, but maintaining sufficient skills and knowledge across the breadth of consultant practice to care for patients with illnesses outside his or her sub-specialty discipline.
- A consultant geriatrician, with knowledge and skills in the sub-acute and chronic care and rehabilitation of the elderly in addition to ability in the management of acute health problems.
- A "hospitalist", with particular skills in the management of acute medical problems, including emergency and intensive care management, as needed in many hospitals with no specialists in emergency medicine or intensive care.

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[41] Ahmed A. Allman RM. Kiefe CI. Person SD. Shaneyfelt TM. Sims RV. Howard G. DeLong JF. (2003) Association of consultation between generalists and cardiologists with quality and outcomes of heart failure care. *American Heart Journal.* 145(6):1086-93.

[42] Donohoe MT. Comparing generalist and specialty care: discrepancies, deficiencies, and excesses. (1998) *Archives of Internal Medicine.* 158(15):1596-608.

The College recognises the importance of multidisciplinary teamwork, particularly in the management of chronic and complex illness, and supports opportunities for training in environments that demonstrate such teamwork, both in hospitals and in the community.

The common practice by which a PhD or MD is effectively a pre-requisite for physicians wishing to hold an academic post or be appointed to a teaching hospital especially with the growth of rural clinical schools, may prove too onerous. This is not to devalue the value of research, but it is a question of ensuring that the balance between service, training and research is such that there is an equitable distribution of the workforce.

While further consideration of opportunities for substitution of work practices by other professionals is supported, the special cognitive skills of the consultant physician and paediatrician in the comprehensive assessment, diagnosis and management of complex medical conditions based on the interpretation of clinical and diagnostic findings must be recognised. Opportunities for substitution may be limited in the immediate future given that all disciplines are experiencing similar shortages. Nevertheless, there are examples, particularly in areas that are underserved either geographically or in the number of sub-specialists available, where a different model of care applies.

The service delivered by solo resident or visiting specialists in rural and remote areas may be more consultative in nature, and involve providing support, education and advice to the primary care workers as well as, or in place of, direct assessment and management of the patient. This model of practice is not compatible with fee-for-service reimbursement. The model of care and funding currently operating in the Coordinated Care Trials in some remote communities may provide a model in which consultant physicians and paediatricians can make an appropriate contribution.

In the small specialty of clinical genetics, non-medical counsellors working with geneticists provide routine aspects of assessment and care, and extensive use is made of telemedicine for remote consultations by the consultant. Neither the multi-disciplinary practice nor the tele-genetic consultation is recognised in the Medicare Benefits Schedule.

Recommendations

Balance within Current Medical Workforce

There should be a balanced distribution of the current Australian medical workforce between general practitioners, “generalist” specialists and sub-specialists, between states and territories, and between rural and metropolitan areas, recognising that, at least in the immediate future, there will be shortages in all disciplines of the health workforce.

To achieve this:

- The implications of the ageing population, the associated co-morbidities, the increasing prevalence of chronic illness in both adults and children for models of consultant practice and training of future consultants should be recognised;

- Appropriate triaging between secondary and tertiary care for adults and children referred to consultant physicians and paediatricians should be systematically implemented;
- Efforts of the College to ensure that access to the expertise of adult physicians and paediatricians within and outside of normal working hours is spread across Australia should be supported;
- The current imbalance between numbers of training posts offering only sub-specialist training and those encouraging maintenance of with skills and knowledge to assess and recommend management of adults and children presenting with undifferentiated medical problems and those involving more than a single organ should be rectified;
- Training of consultant physicians and paediatricians should be expanded beyond tertiary hospitals into community and private sector settings to reflect more closely the characteristics of future consultant practice.

Relative Values

The relativities in the Medicare Benefits Schedule should be reviewed in recognition of the influence of the devaluation of the cognitive role of the consultant physician on the distribution of the workforce.

This review should consider:

- The relativity between consultant physician cognitive and procedural items;
- The role of the consultant physician/paediatrician in relation to management plans, team care arrangements, multidisciplinary care plans and case conferences for patients referred from other medical practitioners;
- The relativity with the recently introduced general practice items number 721 to 731 that encompass these services for non-referred patients but also allow substitution by other health professionals to assist in the assessment and identification of patient needs.

Rural Areas

Opportunities should be created for medical graduates from Rural Clinical Schools and bonded Scholarship holders to have the opportunity to continue their internship and specialist training from a rural base should they wish to do so.

Further consideration should be given to models of care for remote areas in which the services of consultant physicians and paediatricians are funded through resource pooling as is currently occurring in Coordinated Care Trials.

Bibliography:

Ahmed A. Allman RM. Kiefe CI. Person SD. Shaneyfelt TM. Sims RV. Howard G. DeLong JF. (2003) Association of consultation between generalists and cardiologists with quality and outcomes of heart failure care. *American Heart Journal.* 145(6):1086-93.

Australian Institute of Health and Welfare (2002). *Chronic diseases and associated risk factors in Australia, 2001*. Canberra: AIHW. Available at <www.aihw.gov.au/publications/phe/cdarfa01/cdarfa01-c00.pdf>

Australian Institute of Health and Welfare (2004). *Australia's Health 2004*. Canberra: AIHW. Available at < www.aihw.gov.au/publications/aus/ah04/ah04-c00-040804.pdf>

Australian Medical Workforce Advisory Committee (2003) *Career Decision Making By Doctors In Vocational Training: Proceedings of the Workshop Held to Consider the Findings of the AMWAC Medical Careers Survey 2002 and Possible Future Directions for Vocational Medical Training.* AMWAC Occasional Paper, Sydney

Australian Medical Workforce Advisory Committee (2003) *Specialist Medical Workforce Planning In Australia: A guide to the planning process used by the Australian Medical Workforce Advisory Committee.* Available: <www.health.nsw.gov.au/amwac/ pdf/spec_med_work_plan2003.1.pdf>

Australian Medical Workforce Advisory Committee (2004) *AMWAC Workforce Reviews – Summary of implementation of recommendations – 2004*. Available at <www.health.nsw.gov.au/amwac/pdf/impamwac_2004.pdf>

Bloor K. Maynard A. (2003) *Planning human resources in health care: Towards an economic approach – An international comparative review*. Canadian Health Services Research Foundation.. Available at: <www.chsrf.ca/final_research/commissioned_research/programs/pdf/bloor_report.pdf>

Bodenheimer T. Wagner EH. Grumbach K. (2002) Improving primary care for patients with chronic illness. *JAMA.* 288(14):1775-9.

Commonwealth of Australia *et.al* (2000) *The Relative Values Study*. Available at <www.health.gov.au/internet/wcms/publishing.nsf/Content/health-rvs-rvsstudies>

Dent O (2004) *Clinical Workforce in Internal medicine and Paediatrics in Australia, 2003*. The Royal Australasian College of Physicians. Available at <www.racp.edu.au/hpu/workforce/clinicalsurvey2003.pdf>

Department of Health, Western Australia (2004) *A Healthy Future for Western Australians. Report of the Health Reform Committee.* Available at <www.health.wa.gov.au/hrc/finalreport/index.cfm>

Department of Health and Ageing (2005) *The State of Our Public Hospitals. June 2005 report.* Commonwealth of Australia. Available at <www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-ahca-sooph-index05.htm>

Donohoe MT. Comparing generalist and specialty care: discrepancies, deficiencies, and excesses. (1998) *Archives of Internal Medicine.* 158(15):1596-608.

Gagne R, Leger PT. (2005) Determinants of physicians' decisions to specialize. *Health Economics*; 14 (7):721-35.

Gask L. (2005) Role of specialists in common chronic diseases. *British Medical Journal.*. 330(7492):651-3.

Hall J. & van Gool K. (2001) Market forces: An examination of the Australian health care market and its impact on the medical workforce, in *Papers of the 5th International Medical Workforce Conference* November 2000, ed. Australian Medical Workforce Advisory Committee, Sydney. Available at <www.healthworkforce.health.nsw.gov.au>

Katon W. Von Korff M. Lin E. Simon G. (2001) Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. *General Hospital Psychiatry*. 23(3):138-44.

Kingston M. (2005) Determining the professional attributes of a hospitalist: experience in one Australian metropolitan hospital. *Internal Medicine Journal* 35 (5), 305-308.

Maks J. A. H. & Philipsen, N. J. (2002) An Economic Analysis of the Regulation of Professions, in *The Regulation of Architects*. Antwerpen, Intersentia. Available at : www.fdewb.unimaas.nl/eurecom/professionalregul.pdf

Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Australian Institute of Health and Welfare. Canberra: AIHW, 1999.

Medical Training Review Panel (2004) *8th Report*. Commonwealth of Australia. Available at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-workforceeducation-mtrpcpmec.htm

New Zealand Health Workforce Advisory Committee. (2005) *Fit for purpose and for practice. A review of the medical workforce in New Zealand. Consultation Document*. Available at <www.hwac.govt.nz/publications/fitforpurpose.htm>

Nosworthy J. Campbell D. Byrnes G. Staley C. (2001) *Medical Inpatient Study Report*. Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health.

Or Z. Wang J. Jamison D. (2005) International differences in the impact of doctors on health: a multilevel analysis of OECD countries. *Journal of Health Economics*. 24(3):531-60.

Retzlaff-Roberts D. Chang CF. Rubin RM. (2004) Technical efficiency in the use of health care resources: a comparison of OECD countries. *Health Policy*. 69(1):55-72.

Schofield DJ. Beard JR. (2005) Baby boomer doctors and nurses: demographic change and transitions to retirement**.** *Medical Journal of Australia*. 183(2):80-3.

Starfield B. Shi L. Grover A. Macinko J. (2005) The Effects Of Specialist Supply On Populations' Health: Assessing The Evidence. *Health Affairs*, [March 15 Web Exclusive]

The Royal Australasian College of Physicians (2005) *Education Strategy, A Work in Progress, 2004 – 2007*. Available at <www.racp.edu.au/members/edu/RACP_EDU_strategy_April05.pdf>

van Doorslaer E. Masseria C. & the OECD Health Equity Research Group Members (2004) *Income-Related Inequality in the Use of Medical Care in 21 OECD Countries*. OECD Health Working Paper N° 14. DELSA/ELSA/WD/HEA (2004)5.

Von Korff M. Tiemens B. (1997) Individualized stepped care of chronic illness. *Western Journal of Medicine*. 172(2):133-7

Wanless D (2002) *Securing our Future Health: Taking a Long Term View*. *Final Report*. Her Majesty's Treasury. UK. Available at <http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm>

WHO (2002) *Technical consultation on imbalances in the health workforce.* World Health Organization 2002. Available at <www.who.int/hrh/documents/en/consultation_imbalances.pdf >

Willison DJ. Soumerai SB. McLaughlin TJ. Gurwitz JH. Gao X. Guadagnoli E. Pearson S. Hauptman P. McLaughlin B. (1998) Consultation between cardiologists and generalists in the management of acute myocardial infarction: implications for quality of care. *Archives of Internal Medicine.* 158(16):1778-83.

Appendix One: Training Programs

SPECIALIST TRAINING PROGRAMS ADULT INTERNAL MEDICINE	THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS
Cardiology Clinical Genetics Clinical Pharmacology Dermatology *(New Zealand only)* Endocrinology Endocrinology and Chemical Pathology *(with the RCPA)** Gastroenterology and Hepatology General Medicine Geriatric Medicine Haematology *(one pathway with the RCPA)** Immunology and Allergy *(one pathway with the RCPA)** Infectious Diseases Intensive Care Medicine *(with JFICM)** Medical Oncology Nephrology Neurology Nuclear Medicine *(one pathway with the RANZCR)** Palliative Medicine Respiratory Medicine Respiratory and Sleep Medicine Rheumatology Sleep Medicine	**Adult Medicine Division** **Admission to Fellowship: FRACP** * Admission to both FRACP and Fellowship of the other College/Faculty.

JFICM	Joint Faculty of Intensive Care Medicine
RCPA	Royal College of Pathologists of Australasia
RANZCR	Royal Australian and New Zealand College of Radiologists

Training Programs (continued)

SPECIALIST TRAINING PROGRAMS **PAEDIATRICS & CHILD HEALTH**	**THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS**
Clinical Genetics Community Child Health General Paediatrics Neonatal/Perinatal Medicine Paediatric Cardiology Paediatric Clinical Pharmacology Paediatric Emergency Medicine Paediatric Endocrinology Paediatric Endocrinology and Chemical Pathology *(with the RCPA)** Paediatric Gastroenterology and Hepatology Paediatric Haematology *(one pathway with RCPA)** Paediatric Immunology and Allergy *(one pathway with RCPA)** Paediatric Infectious Diseases Paediatric Intensive Care Medicine *(with JFICM)** Paediatric Medical Oncology and Haematology Paediatric Nephrology Paediatric Neurology Paediatric Nuclear Medicine *(with the RANZCR)** Paediatric Palliative Medicine Paediatric Respiratory Medicine Paediatric Respiratory and Sleep Medicine Paediatric Rheumatology Paediatric Sleep Medicine Paediatrics and Child and Adolescent Psychiatry *(with the RANZCP)**	**Paediatrics & Child Health Divisi** **Admission to Fellowship: FRACP** * Admission to both FRACP and Fellowship of the other College/Faculty.

JFICM	Joint Faculty of Intensive Care Medicine
RCPA	Royal College of Pathologists of Australasia
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists

Training Programs (continued)

SPECIALIST TRAINING PROGRAMS **OTHER**	**THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS**
Addiction Medicine	**Australasian Chapter of Addiction Medicine** The Royal Australasian College of Physicians 145 Macquarie Street Sydney NSW 2000 **Admission to Fellowship: FAChAM**
Intensive Care Medicine Paediatric Intensive Care Medicine	**Joint Faculty of Intensive Care Medicine** The Royal Australasian College of Physicians and the Australian and New Zealand College Anaesthetists 630 St Kilda Road Melbourne VIC 3000 **Admission to Fellowship: FJFICM**
Occupational Medicine	**Australasian Faculty of Occupational Medicine** The Royal Australasian College of Physicians 145 Macquarie Street Sydney NSW 2000 **Admission to Fellowship: FAFOM**
Palliative Medicine	**Australasian Chapter of Palliative Medicine** The Royal Australasian College of Physicians 145 Macquarie Street Sydney NSW 2000 **Admission to Fellowship: FAChPM**
Public Health Medicine	**Australasian Faculty of Public Health Medicine** The Royal Australasian College of Physicians 145 Macquarie Street Level 6, 99 The Terrace Sydney NSW 2000 Wellington, New Zealand

	Admission to Fellowship: FAFPHM
Rehabilitation Medicine	**Australasian Faculty of Rehabilitation Medicine** The Royal Australasian College of Physicians 145 Macquarie Street Sydney NSW 2000 **Admission to Fellowship: FAFRM**
Sexual Health Medicine Established 2004 with training to commence under the Chapter by 2005.	**Australasian Chapter of Sexual Health Medicine** Sydney Sexual Health Centre Sydney Hospital Macquarie Street Sydney NSW 2000 **Admission to Fellowship: FAChSHM**