REVIEW OF HEALTH WORKFORCE

SUBMISSION TO THE PRODUCTIVITY COMMISSION

BY THE

Australian Medical Association
CANBERRA, ACT
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Opening comments

The AMA welcomes the Productivity Commission inquiry. We have read the Issues Paper with interest and believe the Productivity Commission has outlined a comprehensive and balanced approach and it should lead to a more informed debate about health workforce issues. It is an area where, in the past, policies have been based on ideology rather than evidence.

It is an opportunity for objective analysis in a difficult area. The AMA interest is predominantly in medical workforce issues. Given the long lead times in medical workforce training, there is ample scope to get workforce projections wrong. In fact, you could say this is the only certainty in this debate. With the benefit of hindsight, it is now clear that the GP workforce was going into undersupply in 1996 at precisely the time that the Federal Government introduced its provider number legislation and reduced GP training numbers dramatically.

It is not helpful to lay the blame for all the workforce related problems in the health system at the feet of the profession, particularly the Colleges. Governments are deeply involved in health workforce planning through their health and education funding decisions. The Federal Government alone controls the number of medical undergraduate places. In relation to General Practice, the Federal Government has total control over training numbers through its funding powers. In relation to specialist training, Federal and State Governments between them have substantial control over the number of training places. Their total control over the environment in Australia's public hospitals includes the number of beds, operating theatre capacity and availability, trainee supervision and trainee availability.

The AMA has serious concerns about current teaching and training availability and standards in the public hospital system. Our observations would lead us to conclude that the standard of today's training is being seriously affected by bed and theatre closures, lack of time for training and professional development, excessive hours of work imposed on trainees and teachers alike and heavy administrative workloads. Related issues such as growing levels of bureaucracy, uncompetitive salaries and cost shifting are having an impact as well.

The rapid increase in the number of medical students who will enter postgraduate training after 2008 will compound this problem.

The full impact of these developments will not be apparent for many years. They will manifest in a slow, steady decline in the future quality of care and the outcomes of care in the Australian health system.

We think there have been some helpful developments in relation to medical workforce planning. The Access Economics study, which has been provided to the Productivity Commission, properly analysed the demand for General Practice services for the first time. AMWAC has taken some of this on board for GPs at least.

Insufficient effort goes into retention strategies for the existing workforce. The Australian Bureau of Statistics report into the private medical sector showed that there is a big bulge of both General Practitioners and Specialists in the 55yrs and over age category. It is this group which has been seriously targeted by workforce retention strategies in the UK. In Australia,

there has been less willingness to acknowledge the impact of remuneration on the supply side and this Inquiry is a good opportunity for some of these issues to get on to the agenda.

Quality and safety

Australia has a good health system. It is characterised by a high number of low cost quality health services at a reasonable share of GDP. We provide 220 million medical services, not including those provided in public hospitals. In addition, we admit approximately 330 patients per 1000 population to our hospitals each year. The average charge for a medical service in Australia is $49.50. Australians have good access to affordable services and we spend around the OECD average at 9.5% of GDP on health.

A health system is its workforce in essence and the Australian health workforce has been a highly trained and motivated one with adequate opportunity for teaching, training and research. We have been able to say with confidence that the quality of care and outcomes of care improve each year.

The Centre for Disease Control in the United States of America has reported on the reduction in deaths from heart attacks over the period 1980 to 2000. The rate of death from heart attack has declined from 345.2 to 186.9 per 100,000 age-adjusted population. We have been unable to locate equivalent Australian figures but we would make the confident assertion that they are very similar in trend.

This enormous improvement in health outcomes has come about through a large number of innovations and advances in medical management of patients. These include the introduction of cardiac care units bringing more specialised medical and nursing skills to bear on patients, the introduction of cardiac artery bypass grafting surgery, new drugs such as beta blockers, blood thinners and clot busters such as heparin and streptokinase, angioplasty, cardiac defibrillators, drug-eluting stents, statins and anti hypertensive therapies.

A similar story can be told for stroke which has seen death rates decline from 96.2 to 60.8 per 100,000 between 1980 and 2000. This is due to a range of improvements such as sub acute rehabilitation, improved medical imaging (CT, MRI), improved surgical techniques for treatment of aneurysms and improved availability of anti hypertensive management and medication.

All surgery has become safer as a result of improvements in perioperative anaesthesia management. According to an ANZCA triennial study in 1997-99 perioperative death associated with anaesthesia is now as low as 1 per 79,500 operations in Australia, down from 1 per 68,000 in the equivalent 1991-1993 study and markedly down on other studies covering the 1970s onwards.

Equally impressive have been the changes to Obstetric and Paediatric practice which have resulted in a big decline in fetal and neonatal deaths in Australia. Between 1980 and 2003, perinatal deaths in Australia have reduced from 13.9 per 1000 births to 8.0 or 42%.

The Cochrane Review, accepted as the highest level evidence possible (Level 1), published an international review in November 2004 of evidence comparing perinatal deaths in birth centres and conventional hospital care. The review found an 83% higher risk of perinatal death in birth centres in a sample size of 8677 women overall and warned that caregivers and

clients using birth centres "should be vigilant for signs of complications". There is now good quality evidence that the substitution of Obstetricians in birthing is associated with higher perinatal death rates.[1]

Australia has recorded a steady but impressive reduction in maternal mortality rates over the last 35 years. It has fallen from 12.7 per 100,000 confinements in the triennium from 1973-75 to 8.2 per 100,000 confinements in 1997-99, a reduction of more than 35%. This compares favourably with the UK which recorded 11.4 for 1997-99 and the US with 17.0 in 2000.[2]

The improvement in health outcomes is not limited to high technology specialty practice based around hospitals. Some of the greatest gains have been in primary care through better care and management by General Practitioners. Improvements in the management of chronic diseases such as asthma, diabetes and mental health conditions are good examples of this and there have been huge benefits to the community through these improvements delivered by General Practitioners.

These improvements have come about through the efforts of the broad health workforce as it has evolved over the last 30 years. Those who advocate intervention through the promotion of widespread substitution of responsibilities in health care, or the abolition or reduction of the role of the Colleges must recognise the consequent slow down or halting of the advances in health outcomes and safety the community has come to expect.

No one will regard it as a particularly clever achievement to claim to have provided substantially more health services if those services are provided at a lower level of quality. Changes occur naturally in the workplace over time with appropriate safeguards, training and supervision and moves to force change have more unpredictable outcomes.

Many of the proposals for substitution would have a marginal impact on the availability of medical practitioners and create very significant quality and safety issues at first consideration. It is up to the proponents of these schemes to make the case that they can be introduced without detriment to quality and safety. The burden of evidence needs to be with them.

Proponents of substitution do not acknowledge that there are significant limitations on the extent to which tasks can be taken out of the hands of medical practitioners or away from their supervision. These limitations include the inability of lesser trained groups to appreciate the complexity of medical decision making and treatment options. Many local signs and symptoms are indicative of more general disease and selective training in a particular disease, organ or tissue fails to adequately prepare the treating practitioner to recognise the broader disease involved. Further, even if appropriate treatment is initiated it is even less likely that non medical practitioners will have the education or expertise to recognise, diagnose and manage complications of their therapeutic interventions.

However, pressure to deliver health care in a timely, effective and safe manner in complex environments, requires new models of care to be investigated. Initiatives to develop the

[1] Hodnett ED, Downe S, Edwards N, Walsh D. Home-like versus conventional institutional settings for birth (review) 2005 The Cochrane Collaboration. John Wiley & Sons.

[2] King JF, Slaytor EK, Sullivan EA. Maternal deaths in Australia 1997-99, Med J Aust 2004; 181: 413-414

clinical role of nurses in General Practice are such an example. Nurses are employed by and act under the supervision of General Practitioners to extend the breadth of primary care available to patients and to free doctors to improve access to more complex care. The key to safe practice in new models of care is that non medical health professionals work in an interdependent, co-operative and supervised relationship with medical practitioners.

In short, we need to do a much better job of ensuring we have a medical and health workforce appropriate to the needs of the population. Australia would be very foolish were it to:

- make the *number* of doctors a sole focus to the exclusion of other key issues;
- sacrifice quality in the pursuit of quantity; and
- fail to deal with excessive and preventable workforce attrition
- fail to bring about the workplace reforms that ensure health professionals are happy and productive.

Recommendations

- ❑ The AMA believes that an emphasis on substitution of tasks away from medical practitioners to other health staff can lead to diminished quality and safety outcomes. AMA accepts there is greater scope for team based models of care under the control of the medical practitioner.
- ❑ The AMA rejects task substitution as a positive reform but supports task delegation to appropriately trained nursing and allied health colleagues. This approach would build on the long history in health of providing health services in clinical teams.

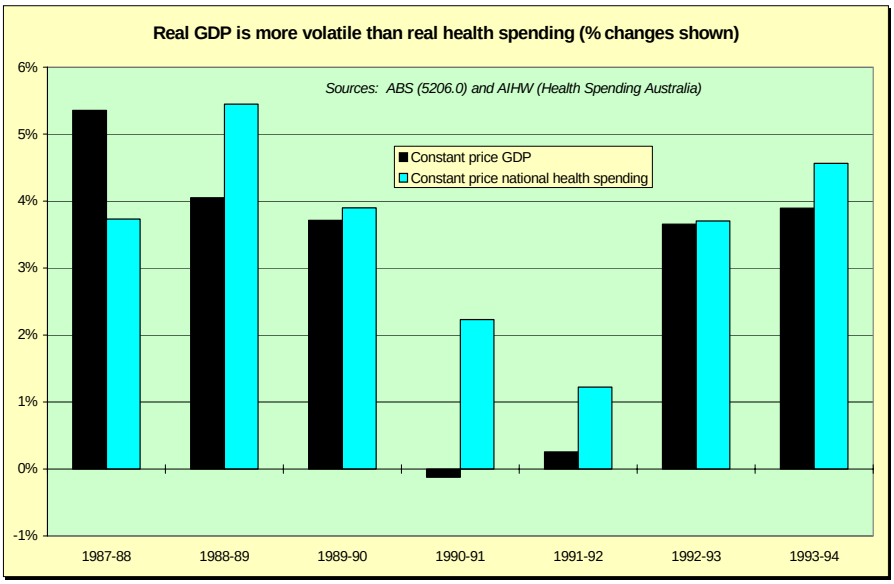
Workforce planning

There is scope for criticism of the efforts of governments in health workforce planning and for suggestions as to how they can do better. Why do governments 'get it wrong'? AMA suggests that there are four main reasons:

- Policy decisions are taken for the wrong reasons (especially in response to short term Budgetary or electoral pressures) and with insufficient regard to the health needs of the population;
- There is a tendency to 'overshoot' in both directions (train too many, then too few, then too many). This overshooting makes no sense whatsoever as health spending has risen steadily and inexorably as real incomes rise (health is a 'superior' good) and as populations age. When health spending rises or falls relative to GDP, more often that not it is due to the fact that GDP has fallen or risen faster. In other words, in the ratio of health spending to GDP, the denominator is more volatile than the numerator (especially evident in the last recession in 1990-92, see chart below).
- Policy decisions on the health workforce are taken with a lack of lateral thinking. For example, when the Federal Government first increased GPET training numbers, the Federal Health Department had not properly considered where the extra GP trainees would come from apart from suggesting they might be recruited from hospitals (leaving a bigger workforce shortage in the hospitals). The solution was to rob Peter to pay Paul.

Subsequently, the penny dropped and medical school intakes were increased. There is still a mismatch between medical school graduates and post-graduate training places; and

- The crude and undeveloped science of health workforce planning is simply not up to the job. Health professionals can be in training for 15 years, or more for some complex sub-specialties. While we have reasonable demographic projections, there is no respectable track record in forecasting the march of technologies that have so much influence over wants, needs and expectations. In short, we cannot foresee the demand far enough ahead to know reliably how many doctors we ought to train.



It is arguably the case that Australia has lifted its game on health workforce planning since the creation of AMWAC a decade ago. AMWAC actively engages many stakeholders in the process and that helps spread an understanding of the issues even at the cost in some circumstances of a low common denominator. The AMWAC methodology has been particularly weak on the demand side and used crude doctor visits per population ratios (themselves affected by shortages) to calculate medical workforce requirements. AMWAC recently sought to improve its demand side capability in its most recent GP workforce modelling and to us, this is a welcome development.

Although their supply side modelling was better, it did not take the vital issue of remuneration into account. It is not always possible to do econometric modelling of the medical workforce as some specialist groups are small and clustered around hospitals and other institutions and require large minimum populations for their existence. But it is possible in relation to General Practice in our view. That said, workforce modelling is still relatively crude and underdeveloped, with much room for improvement.

The Issues Paper raises the spectre of AMWAC processes being captured by professional interests but it is more of a problem that workforce planning has been captured by narrowly-focussed government interests.

AIHW has done a lot of valuable work creating and improving the data sets that are needed to inform decision-making. The importance of that work may be underestimated and the resources applied too skinny.

Recommendations

- The AMA believes that just as it is common practice for Cabinet submissions to require ***environmental impact statements***, a case can be made for all Cabinet Submissions on health policy to require a ***health workforce impact statement***. In short, what is needed is a discipline to make bureaucrats think through the health workforce implications of spending decisions. It is too common for initiatives to fail in their objectives because the strategy lacked the necessary workforce component.
- AMA considers more funding could be provided to AIHW to further improve workforce datasets (See Issues Paper, bottom of p.27).

Education and training

COAG's desire to exercise more control over the relationship between the health and educational sectors has to be considered against their actions in relation to the institutions they directly control. The AMA has serious concerns about the declining state of the public hospital system which must have greater priority than esoteric debates about the relationship between health and education. Nevertheless, some principles should be clearly established such as:

- Training and education should be driven by high standards that focus on quality and safety
- Medical colleges have an enviable reputation for producing highly skilled medical practitioners and their role should not be impeded or diminished unless there is clear evidence that their activities are a problem for the health workforce generally and that alternatives proposed will not reduce the quality of care or the outcomes of care in the long run.
- College fellows contribute a significant portion of their time to training on a pro bono basis. Any alternative arrangement would need to be at least as cost effective as the current system or dollars will be lost from health care provision.
- Colleges are currently going through the AMC and ACCC processes. They are being subjected to greater scrutiny and the involvement of jurisdictions and consumers is being greatly enhanced. Perceptions about transparency are being addressed through these processes. The Colleges are responding to the challenges ahead of them and while they do, they should be allowed to get on with it without further threats over their heads.
- ACCC, by authorising the roles of the Royal Australasian College of Surgeons, supports the position that these functions of Colleges have a net public benefit
- Medical Colleges are currently reviewing issues such as greater recognition of prior learning, trainee representation and advocacy and are meeting the challenges put to them by national competition policy, consumer expectations and workforce demands.
- Opening up training to other providers has the potential to impact on standards. Whereas it is clear Colleges set and maintain standards now, it will not be so clear if other providers are involved. Any confusion around responsibility for setting standards will most likely lead to a reduction in standards and therefore quality. The profession understands the central role of the Colleges in setting standards and we should build on

the existing base to ensure we continue to improve College accountability and transparency.

- Opening up training to competition is highly likely to come at a significantly increased cost. As an example, the per capita annual cost of GP training has risen from $17,700 to $46,600 per trainee since it was taken out of the hands of the College of GPs.
- Education and training are responsive to changing health care needs. Medical students and doctors in training are exposed to real clinical care experiences early in their courses and are directly exposed to the latest methods of clinical care in public hospitals. New methods and improvements in clinical care/surgical technique and new technology flow freely through the system through the various professionally based channels unimpeded by claims for ownership of such clinical care/ techniques or technology.

Better Matching of Training with Healthcare Delivery

- Public Hospitals now largely deal with the more serious end of the acute care spectrum
- Private hospitals are increasingly involved in the treatment of elective surgical and acute medical conditions. More than 50% of all surgery is done in the private hospital system and nearly 40% of all admissions are in the private hospital sector.
- We are moving to the desirable situation where most chronic care is delivered outside the hospital setting.

Recommendations

- ❑ The AMA believes that to take account of the fundamental changes in health care delivery, more training needs to take place in private, and community clinical settings – during undergraduate as well as pre-vocational and vocational training years. The Colleges are already piloting programs in surgery, physician, pathology and dermatology training. To ensure that standards are maintained, the extension of training should be properly regulated by the Australian Medical Council, Postgraduate Medical Education Councils and the Colleges.

- ❑ The AMA considers that education reform initiatives need to be underpinned by a consideration of the retention or improvement of standards and quality and be done in consultation with the Colleges

Regulation of the health workforce

There must be certainty that regulation of the medical profession is maintained at a level sufficient to protect the public with the removal of unnecessary regulation. Doctors are subjected to a huge amount of regulation and it is increasing daily. They themselves have to be registered and are subject to the scrutiny of medical boards. If they practice near State or Territory borders, they are required to be registered (and pay registration fees) in two or more places and are subject to scrutiny by multiple medical boards. Attempts by the medical profession to introduce a drivers licence type model for registration created a bureaucratic

nightmare with all sorts of adjunctive regulatory requirements but without achievement of the main aim.

The AMA supports rigorous processes for medical practitioner registration– perhaps more rigorous given Bundaberg. However it is important that unnecessary processes be removed with the introduction of genuine national registration at no additional cost to the practitioner.

There are requirements for multiple MBS and PBS provider numbers for doctors practising in more than one location.

College requirements are increasingly likely to include evidence of Continuing Professional Development. If a medical practitioner performs procedures in rooms, day surgeries or private or public hospitals, there will be requirements at State, Federal and private health insurance level for accreditation of practices, licensing of facilities and credentialing of individuals. There is a bewildering array of regulation around private health insurance as it applies to day surgery and gap cover schemes.

It is estimated that up to 25% of a GP's time is spent in non face-to-face activity related to the delivery of primary care – not including bureaucratic and business processes[3]. The same survey found that doctors ranked administrative problems in their top five problems in running a practice.

An AMA survey found that 52% of GPs spend between 5 and 10 hours per week completing paperwork. A separate survey estimated that around half of all GPs spend more than 3 hours per week on completing paperwork associated with blended payments alone.[4] The Productivity Commission in its review of the GP administrative burden estimated that in 2002 red tape cost each Australian GP an average of $13,000 per annum.[5]

Reducing red tape and bureaucracy, and providing more opportunities for GPs to spend face-to-face time with patients must be a key priority. It will improve the image of general practice and allow GPs to increase their patient load, and impact positively on morale. The recommendations of the Productivity Commission related to the administrative burden on GPs are being slowly and gradually implemented but more can be done to reduce red tape without reducing quality of care.

Many of these regulatory activities are not related to safety and quality and where a relationship is claimed, such alleged relationship cannot be demonstrated by evidence. A medical practitioner's unwillingness to be subjected to these regulations is often regarded as prima facie evidence of having something to hide, whereas the truth is more related to a focus on delivery of quality clinical care or protection of personal privacy.

[3] An Analysis of the Widening Gap between Community Needs and the Availability of GP Services – A report to the Australian Medical Association by Access Economics Pty Ltd, Canberra, ACT. February 2002
[4] Australian Doctor Survey May 2002.
[5] General Practice Administrative and Compliance Costs. Research Report. Productivity Commission, 31 March 2003.

Workforce participation

A strong primary care workforce is shown to deliver better overall health outcomes in the community. General Practitioners are the most highly trained health professionals who provide general care to patients. They are the gatekeepers to the health system and ensure that only necessary referrals to the more expensive specialist sector go ahead.

The GP workforce cannot keep up with community demand and other specialties are more attractive to junior doctors. Government must make General Practice more attractive through better remuneration, a funding structure that rewards quality practice, further reductions in red tape and expansion of the GP pre-vocational training scheme in order for it to encourage more junior doctors to gain general practice experience.

There is an untoward focus in the Productivity Commission's Issues Paper on training more health professionals and far too little regard for issues of retention and work satisfaction for those already in the workforce. Given the training of health professionals is an expensive exercise, Australia cannot afford to 'waste' people by training them for health professions then driving them out to other occupations due to a combination of inadequate monetary compensation, poor working conditions, excessive red tape and inadequate career development.

More than 30% of the GP workforce are over 55 years of age. It is a similar figure for specialists. These are the males working long hours each one of whom needs to be replaced by 1.6 newly trained doctors. We need strategies to prevent these doctors from retiring or becoming disaffected with the system.

In relation to General Practice, actions must be taken to resolve the situation of the non VR general practice workforce. Although the number of non VR general practitioners has declined over the years, there are approximately 2,500 doctors in the category. Government policy has not encouraged continued participation of this group for reasons which were accepted and valid in the early 90s when we had an abundance of General Practitioners.

The AMA believes we now need to develop measures to encourage these practitioners to stay in the general practice workforce and some form of grandfathering arrangement must be sorted out to enable their patients to access VR rebates. The grandfathering needs to be subject to certain conditions but the non VR General Practice group is too large to risk alienation by a continuation of existing policy.

Recommendations

- The AMA recommends a close examination of retention and recruitment strategies in comparable countries such as the UK to see what Australia can achieve in this area. These can include but are not limited to, direct financial incentives, taxation concessions, support for professional development, superannuation reform and locum relief.
- The AMA recommends the development of incentives that include the offer of extra hours to encourage medical practitioners, particularly General Practitioners who are working part time to work more hours.
- The AMA supports measures to improve retention of non VR general practitioners.

Migration issues

There is a world wide shortage of medical practitioners and as noted in the Productivity Commission Issues Paper, the medical workforce is an international one. Recruiting large numbers of medical graduates from overseas will become increasingly difficult and expensive.

In 1993/94 670 OTDs were granted temporary resident visas. By 2003/04 this number had grown to 2,249. Around 400 to 500 permanent resident OTDs have arrived in Australia each year since 1997/98.[6]

The mix of OTDs has also changed dramatically. In 1997/98 the great majority of OTDs came from the United Kingdom (70% of arrivals), whereas this number dropped to 43% by 2002/03[7]. Increasing numbers of OTDs are arriving from countries with quite different medical training structures to those in Australia.

In the past there may well have been significantly less criticism of OTD assessment processes simply due to the fact that the vast majority were from countries offering similar training and qualifications to those offered in Australia. However, this has now changed and there is no doubt that this, along with increased OTD numbers is increasing pressure on stakeholders to implement more vigilant assessment processes.

OTD assessment and registration processes vary from State to State and are fragmented, inconsistent and confusing. Some applications are processed quickly, others take months – with no apparent reason for the difference.

One of the most disappointing aspects of OTD recruitment is the lack of a formally mandated orientation process about living and working in Australia. While some programs are available and some employers take this seriously, the majority of OTDs receive little support - making their transition into the medical workforce even more difficult.

Supervision is also a significant problem. Often supervisors of OTDs lack the qualifications and skills to do so, and in some cases supervision responsibility is simply ignored. These matters are not just the concerns of the AMA. The MTRP OTD Subcommittee report focused on these issues, with stakeholder feedback indicating that OTDs were poorly served in both supervision and support.

Recommendations

- The AMA supports the implementation of a stronger, nationally consistent and properly funded processes for OTDs based on:
  - Ethical recruitment practices;
  - Rigorous and consistent standards of assessment – including English language requirements for those for whom English is not their first language;
  - Validation of qualifications by the relevant Medical Board, or the Australian Medical Council;
  - Minimal red tape and no unnecessary bureaucracy;

[6] Arriving in Australia: overseas trained doctors, Dr Robert Birrell, Medical Journal of Australia 6/20 December 2004.
[7] Op cit, Arriving in Australia: overseas trained doctors.

- Prior assessment of competency by the relevant College or other equivalent standards body based on an appropriate comparison to Australian trained doctors;
- Greater support for OTDs including orientation, education and access to community services.
- Greater attention paid to ensuring that proper efforts to recruit locally are pursued. With recent visa changes, there is now no nationally consistent work test applied before an OTD can be recruited. An employer need offer an annual salary of around just $39,100.
- Stronger tests to establish area of need and encourage employers to offer appropriate conditions and ensure OTDs are recruited where they are most needed.

Productivity

Over the last 20 years there have been dramatic gains in productivity in the health system. Length of stay per admission has come down from nearly 7 days in 1986-87 to 3.5 days in 2002-03 and day surgery now represents 55% of all admissions. Changes in anaesthesia techniques have been largely responsible for the reduction in length of stay and in allowing work to transfer from overnight to day surgery settings.

There have been substantial reductions in the time taken to perform procedures (eg lens extraction and insertion) and in the period required for recovery after surgery (laparoscopic surgery) which has implications for the broader economy.

New pharmaceuticals have rendered some surgery obsolete (surgery to repair stomach ulcers) while other work has been taken up by lesser trained health professionals such as Practice Nurses working under the direction of General Practitioners in immunisation, wound management and population health services generally.

Without implying any criticism of AMWAC, their methodology is not good at factoring in the impact on workforce projections from productivity increases from various sources including technological change.

Insufficient attention is paid to the negative impacts on productivity arising from the dysfunction in the health system (especially the public hospitals systems), the high administrative overheads and the many ways in which appropriate clinical issues are excluded in management's decision-making. Poor management practices *reduce* the productivity of the hospitals.

The AMA does not have recent data but a survey previously conducted by Roy Morgan of the medical workforce found the major explanation for inability to clear waiting lists or provide services within category times, was a shortage of operating sessions and the curtailment and cancellation of sessions. Surgeons were willing to supply more services but for budgetary reasons the sessions were not available. We suspect this would be as true today as it was then and the AMA is presently undertaking a survey of the surgical and physician workforce to check this.

Recommendations

- ❑ The AMA recommends that organisations with expertise in workforce modelling in Australia and overseas be canvassed to determine if there are available methods to predict the impact of productivity improvements in workforce modelling in Australia.

- ❑ The AMA encourages the Productivity Commission to investigate the impact of public hospital budget constraints on the utilisation of public sector facilities and resources including the medical and nursing workforce.

Demand

The factors which affect patient demand for the services of health professionals are well documented and increasingly studied. The ageing of the population is an ever-present contributor to the growth of demand for health services. In economic parlance, ageing moves patients along the demand curve to a higher utilisation point.

For their own reasons, governments have often down-played the impact of an ageing population. It used to be said that ageing added only 0.3% p.a. to health spending. Now the figure most commonly used is 0.5% p.a. The ageing effect is ramping up over time and it will not stop at 0.5% p.a. In some areas of medical practice, the ageing effect is already well over 1% p.a. Cataract surgery is a good example. Over the period 2003-04 to 2013-14, the demand for cataract surgery is forecast to increase by 23.5% based on population growth alone. With population growth and population ageing, the forecast growth is 86%. Of course, a dramatic breakthrough in prevention could change the paradigm. Perhaps more likely is some income effect over and above population growth and ageing.

The ramping up in effects of ageing does not yet appear to have had any visible impact on health workforce planning.

Historically, changes in expectations have been far more important than the ageing effect. In economic parlance, changing expectations lift patients to a new and higher demand curve. Changing expectations reflect many factors, but notably:

- Rising real incomes (since health is a 'superior good', as real income rises people will direct more of their discretionary expenditure on health care and may also expect governments to give more emphasis to health care in allocating taxpayers' funds); and
- Changing health technologies which increase the quality and range of possible treatments.

Some of the increase in expenditure will be of a discretionary nature (eg plastic surgery) which may require some tightening of the boundaries of health insurance (it is very hard to make a case for health insurance to cover discretionary expenditure). That said, workforce planning needs to look beyond what is insured.

A key issue is that the demand for health services does not immediately translate into a demand for health professionals. The increasing productivity of the health workforce, with very high gains in some procedural areas, is not given anywhere near enough consideration in planning for likely future requirements.

Recommendation

- ❑ The AMA recommends that the Productivity Commission should examine methods of promoting more sophisticated workforce modelling approaches, building on the early work of Access Economics and others particularly as these enable prediction of the increase in the demand for medical services.

Regional and remote issues

The AMA has identified medical workforce shortage as a major health issue. Not only is there a nation-wide shortage of doctors, the overall distribution of doctors is skewed heavily towards the major cities such that regional, rural and remote areas shoulder a disproportionate workforce shortage burden.

Put simply, there is a strong preference amongst much of the current medical workforce to live and work in major cities – with particular preference for the inner suburbs. Given the educational background and the demographics of the current medical workforce – this should come as no surprise. Doctors are no different to any other professional group and evidence throughout the western world shows that attracting and retaining young professionals to rural and other locations is extremely difficult.

The debate is not just about numbers. It is also about the right skill mix. Rural medicine, in particular, requires strong procedural skills - with primary care practitioners representing the backbone of rural health care. With strong trends toward sub-specialisation, and declining numbers of rural GPs who are practising proceduralists, the problems facing regional and rural communities are even more acute than the overall distribution of the workforce would suggest.

There are several areas where policy makers can influence both the supply and distribution of medical practitioners. These include:

- Medical school intakes and selection practices
- Training curricula and program requirements
- Recruitment and retention initiatives for medical practitioners
- Flexible work arrangements allowing a better balance between work and personal/family commitments
- Development of improved work practices and the provision of appropriate resources to support medical practitioners in the delivery of health care
- Access to services, resources and amenities – community and professional alike
- Reducing compliance costs involved in delivering healthcare and running a small business

Recommendations

- ❑ The AMA recommends that although no country has developed a package of policy initiatives that completely address problems in the distribution of the medical workforce, there are several emerging lessons that the Productivity Commission needs to take into account when formulating policy responses such as:

    - The early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas

- Proper medical infrastructure, a strong training experience, and access to community and professional resources such as paid locum cover, and continuing medical education including paid conference leave are essential to the provision of a rewarding professional and personal experience and the retention of medical practitioners.
- Hours of work must be made more reasonable and on call rosters must be realistic. Consideration must be given to not only the needs of the medical practitioner, but also their family – particularly with respect to access to employment opportunities, health and education, and social amenities.
- A critical mass of doctors within a region is important in improving the viability of a practice, as well as enhancing professional development
- Appropriate remuneration and incentives are essential to attract and retain medical practitioners
- Young prospective medical school students are poorly equipped to make decisions that commit them to a period of service in areas of workforce shortage and as such unfunded bonding of medical school places is unlikely to lead to a sustainable improvement in workforce distribution.
- Return of service obligations for medical students should be incentive based and include measures such as scholarships and HECS relief. Entry to medical school should not be conditional on agreeing to work in an area of workforce shortage, a condition which comes into effect many years after it is entered into.

❑ The AMA opposes geographic provider numbers as a means of regulation. Locking in younger doctors to a career in certain areas tends to discourage rather than promote participation. For example, the rural pathway in GP training has been heavily undersubscribed in the past as it locks people into a career choice rather than allowing them to sample rural medicine – which would encourage more people to at least look at a career in rural medicine.

❑ The AMA considers that delivery of medical services is about more than simply numbers. There are good and cogent reasons why many specialists are located in larger regional centres and major cities. Access to support, infrastructure, caseload and training opportunities are all important factors. Therefore other innovative means of delivery must be examined.

❑ The AMA supports outreach programs to provide funding assistance for specialists visiting rural and remote areas. These are a valuable means to enhance the delivery of services in these areas and should be adequately funded and based upon the following principles:

- Services must be directed to communities where an unmet need is identified by the local medical practitioners
- Services must be designed to fit in with local healthcare services, and wherever possible they should include up-skilling and other measures to enhance the sustainability of local medical services
- Funding must be available to existing outreach services

- There should be strong Medical College involvement in outreach programs in order to encourage greater participation

Indigenous

The health status of Aboriginal peoples and Torres Strait Islanders in Australia is unacceptable. In 2003 Professor John Deeble calculated that the health care services provided to Aboriginal peoples and Torres Strait Islanders was under funded by $300 million per year. This was confirmed and refined in 2004 by Access Economics who, using a new methodology, estimated that the current primary health care services provided to Aboriginal peoples and Torres Strait Islanders is under funded by an estimated $400 million per year.

The Access Economics analysis also estimated the size of the critical shortage of health professionals providing services to Aboriginal peoples and Torres Strait Islanders (430 doctors and 450 others). The cost to fund these additional training places to address the total shortfall of all health professionals would be $36.5m/year ($167m over 6 years).[8]

To address this shortfall the AMA has called on the government to:

- provide additional fully funded training to address the total shortfall of health professionals providing services to Aboriginal and Torres Strait Islanders.
- explore incentives for medical officers working in Aboriginal Medical Services and seek support from the relevant medical colleges for registrars to be available and credentialed for working in Aboriginal Medical Services to ensure there are sufficient health staff available to work with Aboriginal and Torres Strait Islander communities.

The AMA believes that there is a strong link between the health of indigenous people and their access to indigenous health professionals. At present Indigenous groups are significantly underrepresented in the whole health workforce, not just the medical profession.

Therefore the AMA believes that to improve the health outcomes of Aboriginal peoples and Torres Strait Islanders it is critical to increase the proportional representation of this group within the general medical workforce. To increase the proportion of Aboriginal peoples and Torres Strait Islanders working as health professionals to non-Indigenous levels 928 doctors, 149 medical imaging professionals, 161 dentists, 2570 nurses, 275 pharmacists, 119 occupational therapists, 59 optometrists, 213 physiotherapists need to be trained. In additional a further 2000 Aboriginal health workers are also required.

In 2004 the AMA called for the allocation of fully funded training places to close this gap.
A program to close this gap would take at least 10 years to enrol sufficient students and probably longer unless there is an active program in schools supporting and encouraging Indigenous individuals to aspire to become health professionals. All efforts must be made to ensure those that do enrol have the best possible chance of completing training. To do this the AMA has previously called on the Australian Government to:

- recognise the need for Aboriginal and Torres Strait Islanders to be represented at the same level as they are in the population in all health related professions and support

[8] Access Economics paper 2004 (Colin can find the proper title from my g drive he found the Discussion paper for me and is in the same file).

professions (eg management). To achieve this the government must institute a funded National Aboriginal and Torres Strait Islander training programme including:

- Allocation of sufficient places in training programmes to Aboriginal and Torres Strait Islanders to achieve parity by 2010;
- Establishment of support units at all those training institutions with these allocated places;
- Provision of full scholarships including living expenses for allocated places where necessary;
- Establishment of mentoring programmes in schools to identify and support Aboriginal and Torres Strait Islander children from primary school through to training institutions.

In addition to ensure that all health professionals providing services to Aboriginal and Torres Strait Islanders are able to provide high quality services the AMA advocates that:

- all health personnel training programmes, including specialist training colleges include, as part of the core curriculum, components on Aboriginal and Torres Strait Islander health including cultural awareness and safety.
- the government support initiatives aimed at ensuring doctors, student doctors and doctors-in-training receive the right information and skills development in the best interest of improving Aboriginal and Torres Strait Islander health outcomes.

Recommendation

- ❑ The AMA asks the Productivity Commission to support the AMA's submissions to Government for significant additional resources into aboriginal health as outlined above, including programs to increase the size of the aboriginal health workforce and the training available.

After hours GP services

The AMA supports the right of all Australians to timely, appropriate primary medical care. It is, however, unreasonable to expect any doctor to be available 24 hours a day.

GPs and their practices have an ethical and professional obligation to ensure that their patients have continuous access to appropriate care and continuity of care.

GPs are inadequately remunerated and insufficiently recognised for providing out-of-hours primary care. The Medicare Benefits Schedule does not adequately reflect the skills and responsibility required to properly conduct such consultations, and the particular demands the delivery of such care places on GPs.

A GP workforce shortage across Australia is a critical factor in the capacity of the profession to meet demand for out-of-hours services. Australia has a shortage of over 2,000 full time equivalent GPs. The participation rate in general practice is now about 64% and falling. The "feminisation" of the workforce is the most significant factor that will impact on participation rates into the future. Between 1991 and 2003 the proportion of female GPs increased from

19.3% to 35.2%[9]. Female GPs are more likely to work few sessions per week and on average have longer consultations[10].

While the demand for part time work is a key feature of the female workforce this trend is now being followed by their male counterparts[11]. A recent study indicated that the loss of male GP working hours between 1999 to 2003 was equivalent to the loss of around 575 full time equivalent GPs[12]. AMA figures collected in 2003 indicated an average working week for GPs of 50 hours but a preference to reduce working hours to an average of 36. A drop in average GP time of 2 hours per week per GP is equivalent to the loss of about 1,000 GPs from the workforce.

Barriers to Provision of Out-of-Hours Care

Key factors that impact on the provision of out-of-hours care by general practitioners include:

- inadequate total number of GP out-of-hours workforce;
- national GP workforce shortage;
- excessive workload and working hours to meet the demands of in hours services;
- safety risks for GPs attending unfamiliar situations and patients alone, particularly late night and early morning;
- extremely limited or no access to locums;
- inadequate financial support for existing out-of-hours GP arrangements;
- limited access in rural/remote Australia due to geography/demography, together with downgrading and closure of local hospitals and facilities;[i]
- no adequate on call allowances for most rural GPs servicing state hospitals;
- insufficient provision of hospital facilities for primary out-of-hours medical care as triage and assessment centres and bases for visiting doctors;
- poor awareness of available GP services;
- insufficient patient education which contributes to:
    - increased expectation that the service will be timely, free and convenient, though not necessarily appropriate;
    - lack of awareness of other available services that may be more appropriate in emergency situations, e.g. ambulance in cases of severe asthma or chest pain.

[9] While women represent 35% of the GP workforce, they fill more than 50% of medical school places and 60% of places in general practice training programs.
[10] At 35% of the workforce the Bettering the Evaluation and Care of Health Study (BEACH) found that they carry about 27% of the general practice workload.
[11] A study published in the Medical Journal of Australia (19 July 2004) found the proportion of male GPs working fewer than six sessions a week almost doubled from 6.1% to 11.4% between 1999 and 2003. The proportion of male GPs working longer hours (11or more sessions per week) dropped from 23.8% to 17.1% in the same period.
[12] Should the shift to part time work by male GPs continue its current trend there is an expectation that this will lead to the loss of another 600 full time equivalent GPs between 2003 and 2008.

Improving Access to Out-of-Hours Care

Any strategy, or combination of strategies, that seeks to improve provision of, and access to, 24 hour care for patients must, at a minimum, address the barriers outlined above and consider and respond to the following critical underlying factors:-

- inadequate patient rebates for out-of-hours care;
- the overall increase in patient driven demand for extended hours services;
    - GP attitudes:
    - more GPs are working part-time;
    - concern and attention to safe working hours;
    - interest in other lifestyle activities/quality of life;
    - increased demand for family friendly work practices;
- the increased burden of early discharge and the increased complexity of out-of-hours patient care related, but not limited to, community care of chronic conditions, palliative care, care of the elderly and those with psychiatric illness at home;
- maintaining state rural (community) hospitals with adequate resourcing to all aspects of those hospitals including remuneration to the VMO GP workforce, and;
- lack of access to hospital support for urban GPs.

Recommendations

- The AMA recommends that any model of out-of-hours primary care must incorporate the following <u>essential</u> criteria:-
    - be GP centric in that it acknowledges and incorporates GP expertise in its design, governance and in implementation it places the patient's GP as the prime contact;
    - be locally appropriate;
    - reflect clear and sustainable collaboration between GPs, hospital(s) and community;
    - have the demonstrated support of local GPs and the community;
    - be supported by appropriate remuneration of GPs that reflects the real value of the service provided; and
    - incorporate adequate and defined funding for infrastructure, including information technology management and communication systems.

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