

# requirements provide a sensible basis for planning?



## No

Professor Richard Murray explains why action on generalism, regional training and service reform is a national policy emergency

It might surprise some to know that among wealthy Organisation for Economic Co-operation and Development (OECD) countries, Australia has an average number of doctors for its population.<sup>1</sup>

Australia has more doctors per capita than ever before, more than New Zealand, Canada, the United States and the United Kingdom. With medical graduate numbers rocketing from 1503 per year in 2004 to a projected 3750 per year by 2014, Australia will shortly all but top the OECD in doctor production, some 1.8–2.4 times higher per capita than 2010 figures for the abovementioned countries.<sup>1,2</sup> Despite this, Australia relies heavily on overseas-trained doctors — particularly in rural areas, where they now comprise half the medical workforce — and the poaching of doctors from low-income countries continues apace.<sup>3</sup> How can it be then that an analysis of “demand” for doctors in a recent Health Workforce Australia report could conclude that an extra 37 071 doctors will be required by 2025 — up from 72 134 in 2009 and exceeding population growth by 22%?<sup>4</sup> Such a heroic target will only be met by maintaining record domestic production and continued heavy reliance on imported labour. Even so, modelling predicts a deficit of 2700 by 2025. The truly extraordinary conclusion is that the two-thirds of Australians who live in major cities will need 79% of these additional doctors and, in spite of present inequalities, regional Australia requires just one in five.

Yet the report is welcome. The modelling makes not a whit of sense as a policy prescription, and it therefore exposes the folly of “more-of-the-same medicine” for Australia’s health care future. With luck, it might help galvanise action on how the surge of medical students and junior doctors coming through the pipeline is to be deployed as trainees and fellows. If so, this would not be a moment too soon.

The problem with the analysis is that change relating to technology, workforce and service delivery was not considered as it was too difficult to model. Demand calculations relied on specialty service utilisation data by age group, applied to the demography of 2025. This is “pickled 2009” for an older Australia of 27 million. Injecting a large bolus of medical specialists into an older population with chronic comorbidity and an uncapped insurance system will cause exquisite fiscal pain.

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lost to the “internal brain drain” that is inherent in vertical approaches to managing chronic non-communicable disease.<sup>5</sup>

Health planning in national health systems to reduce health inequalities and organise people-centred care is more important than ever.<sup>6</sup> In health workforce planning, only uncertainty is certain — and patient outcomes are too often overlooked.<sup>7</sup> Despite this, policy choices must be made.

The first principle to guide decision making on medical workforce is clinical generalism. Priorities include the “rural generalist medicine” model of extended community, hospital, emergency and population care, as well as community general practice, general internal medicine, general surgery, general paediatrics and other generalist disciplines.

The second is regionally based specialist training. Were doctor numbers to be equalised across geographic areas by 2025, half of the 37 071 new doctors would need to practise outside major cities. Achieving anything approaching this will require a massive boost in regionally allocated training salaries, innovation in accreditation of training posts, and infrastructure such as accommodation for trainees. We must capitalise on investments in rural clinical schools, scholarships and bonded places for students.

The third is serious reform of health services, financing and workforce. A focus on the needs of underserved communities will be instructive (and rural medicine has much to teach). Doctors must apply themselves to cognitively and procedurally complex medicine and clinical leadership; nurses too, must work at the top of their licence. Many other workers are required, including various health assistants. Given the medical graduate numbers that are on the way, decision making on medical training can truly be described as national policy emergency. Now is the time for action.

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