

# MEDICAL TRAINING: FIRST FARCE THEN TRAGEDY

**Steven Schwartz** prescribes a dose of market forces for Australia's medical workforce training

**I**n his critique of social engineering, Nobel laureate Friedrich A. Hayek forcefully rejected the idea that even the smartest and best motivated government can organise the world according to its own wishes. He called the seemingly inextinguishable belief in the power of central planning the 'fatal conceit.'<sup>1</sup> What follows is a cautionary story about that fatal conceit, especially relevant in this era of neo-Keynesianism where government intervention is becoming the default mode. It shows how central planning, to paraphrase Karl Marx, can result first in farce and then in a tragedy of disappointment and waste.

## Too many doctors?

The story begins in the early 1990s when I was Dean of Medicine at the University of Western Australia. Commonwealth government planners had decided that Australian universities were graduating too many doctors. Their logic went like this: doctors 'create their own demand' by conducting useless consultations, ordering unnecessary tests, and writing futile prescriptions. So cutting back on surplus doctors would save the taxpayers money without affecting health care.<sup>2</sup>

Federal planners were dispatched to medical schools around the country to negotiate reductions in medical student enrolments. In WA, we did what we normally do when the Feds came to visit—we claimed to be a special case and ignored them. But some universities in other states complied and cut medical student enrolments. As a reward, they were to be allowed to retain the government

funds they would have received had the previous number of medical students enrolled. Like the European Union's policy of paying farmers not to grow certain crops, these universities were paid not to teach medical students.<sup>3</sup>

The Commonwealth's intervention achieved its aim; the number of medical enrolments in Australian universities dropped dramatically. There was only one problem—patients still wanted their consultations, procedures and prescriptions. As there were too few Australian doctors to meet patient demand, the doctor supply was augmented by an influx of foreign medical graduates.<sup>4</sup> So, despite the planners' efforts and the bribes paid to universities (which greatly increased the per capita cost of training a doctor), the only thing the planners managed to change was the accent of the doctors.

This farce soon became even more ludicrous. A few years after they successfully reduced the number of medical graduates, the government discovered Australia was not facing a doctor glut, but a shortage.<sup>5</sup> (Central planning is clearly not an exact science.)

To combat the doctor 'shortage,' even more foreign trained medical graduates were encouraged to immigrate and new medical schools were

**Steven Schwartz** is Vice-Chancellor of Macquarie University, Sydney.

established. In a few years, when these schools begin to graduate their full complement of doctors, the total number of Australian medical graduates will jump 81% (from 1,608 in 2005 to 2,916 in 2012). In some states, the number of medical graduates will double.<sup>6</sup>

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Problem solved? Well, not quite. Here is where the story moves from farce to tragedy and waste. It seems that once again, there are too many doctors. At least this is what the current crop of medical students believes. In August last year, they called on the Commonwealth to stop producing more doctors.<sup>7</sup> To understand what is going on, you need to know how medical training works in Australia.

### Medical training

Preparing a doctor for practice is long and arduous; university is only the beginning. After graduating with a medical degree, graduates go to work as an intern in a teaching hospital for 12 months. Interns do routine tasks while also learning professional skills from senior doctors. Medical graduates are not eligible for full state registration until they complete their internships.

But registration is not the end of medical training; registered doctors are still unable to practise. They are only eligible for further training—first in rotations through various clinical settings and then in specialised ‘vocational’ training programs. The right to practise medicine under Medicare requires the successful completion of vocational training and admission to one of the specialist medical colleges (such as the Royal Australian College of General Practitioners).

To obtain vocational training, which is essential if doctors want to pursue an independent medical career, they must apply for a hospital registrar position accredited for training by the relevant medical college or for a training position outside of a hospital (in a GP practice, for example). This is the source of the medical students’ concerns. It seems central planning has again proven itself to be an inexact science. Training places have not

expanded fast enough to keep up with the influx of aspirant doctors. Medical students worry they will not be able to obtain vocational training and, therefore, unable to practise.

They have good reason to be concerned. The same problem has arisen in the United Kingdom, and for the same reason.<sup>8</sup> The supply of training places has not kept up with the vastly increased number of new graduates. An influx of foreign trained doctors only made the problem worse. Last year, many more UK applicants applied for training positions than could be accommodated. Some of the brightest students in the country are finding, after years of expensive training, that they are unable to further their careers. At best, they are condemned to low paying hospital jobs; at worst, they will find themselves driving taxis.

And now the same tragic waste of talent is about to happen in Australia.

Why did the federal government decide to increase the number of medical graduates while not ensuring a comparable increase in the number of training places?

There are two answers to this question.

First, Commonwealth government planners only have access to one part of the medical training system—universities. The Commonwealth provides the funding for new medical schools, thereby increasing the number of medical graduates, but it does not control the other parts of medical education. The recent Bradley Review of Australian Higher Education mentions health and medical teaching but does not address the issue of clinical training, probably because this is not presently within the remit of universities.<sup>9</sup>

The states fund the hospitals that deliver vocational training, and the colleges accredit the training itself. Increasing the number of trained doctors requires coordination between the medical colleges and both levels of government. Alas, neither the colleges nor the hospitals are particularly interested in increasing training places. The fellows of the medical colleges may see a large number of new specialists as a competitive threat. State hospitals may be equally unenthusiastic. Being under-resourced, hospitals prefer to focus on getting patients in and out rather than on training.

The second impediment to increasing training places results from the nature of medical teaching. Doctors undergo a hands-on apprenticeship. Registrars learning to be orthopaedic surgeons, for example, must operate on patients with broken or diseased bones to perfect their skills. At present, registrar training takes place only in public hospitals while half or more operations take place in the private sector. Commonwealth planners can double the number of medical graduates but it is not in their power to double the number of people in public hospitals with bone problems.

### Workforce planning – again

In response to the NSW medical students' complaints, the federal minister for health promised to provide new training opportunities in GP clinics rather than hospitals.<sup>10</sup> She has kept her word. At the Council of Australian Governments (COAG) meeting held in November 2008, the Commonwealth announced that it would fund 212 new GP training places.<sup>11</sup> Money was also promised for training infrastructure in rural areas. But this raises other questions about planning.

In 2012, universities will produce around 3,000 new medical graduates—not just for one year, but every year from then onward. Even if no new foreign medical graduates are allowed to immigrate, and if the normal number of doctors die or decide to retire, drop out or emigrate, we will still have around 50% more doctors in 2020 than we have now. If the vast majority of these new doctors are going to be trained in GP clinics, we will have many more GPs but, unless hospital training places grow, we will have around the same number of surgeons, anaesthetists and other specialists. To deal with this, the COAG agreement also calls for 73 additional specialist places.<sup>12</sup>

How do the planners know that 212 GPs and 73 specialists are the right numbers? As medicine becomes increasingly high tech and customised, is it not equally plausible that we will need more hospital specialists and fewer GPs?

How come the planners, who thought we had too many doctors in the mid-1990s and too few five years later, are now sure that they know what will be needed five years from now? Has workforce planning improved, or are we seeing more evidence of Hayek's fatal conceit? Disappointment and waste are inevitable when we try to impose an

artificial order on complicated social systems.

Politics is the art of the possible and big changes are difficult to implement. But there are some obvious improvements we can make in medical training.

### Opening up medical training

First, it is a good idea to minimise conflict of interest. One way to do this is to remove the monopoly medical colleges have on accrediting vocational training by encouraging universities to offer such training as postgraduate degrees. Universities would be able to coordinate intake numbers to ensure they only accept as many medical students as they are able to accommodate in their vocational education programs. In addition to counteracting the conflict of interest that keeps at least some medical colleges from increasing training places, competition should drive up training excellence as it has in every other area in which it has been allowed to operate.

We need to find a way to allow market signals, rather than central planning, to determine how many doctors we need.

Second, there is no reason why teaching needs to be limited to public hospitals. Private hospitals should be encouraged to develop their own training programs, subject to objective and unbiased quality assurance. Macquarie University, which is developing its own private hospital, will be teaching sub-specialty surgery in its own private hospital and can increase or decrease the number of sub-specialty surgeons it trains in response to supply and demand.<sup>13</sup>

Finally, we need to find a way to allow market signals, rather than central planning, to determine how many doctors we need and in what specialties. This could be achieved by permitting training providers (such as universities) to offer as many places, in as many specialties, as they like. If the supply of doctors begins to exceed demand in one area, trainees will move from one specialty to another until an equilibrium is found. This happens in most other professions—enrolments

in engineering courses are notoriously cyclical depending on the state of the job market—and, in theory, medicine should be no different.

There is one catch, however. Most medical costs are not paid by individuals but by Medicare. If doctors can figure out how to generate their own demand, as the 1990s planners feared, then normal market forces will not work. Trainees will not be deterred from entering low demand specialties if they can artificially increase demand and collect Medicare payments. Patients may not worry about unnecessary tests or referrals because they are not paying the bills.

There are solutions to this problem: medical savings accounts in which patients receive tax advantages to look after their own health care are one possibility.<sup>14</sup> Requiring larger co-payments for treatment is another. Patients are considerably more likely to consider treatments more carefully when it is their money they are spending.

Even if the Medicare rules remain unchanged, there are ways to mitigate doctor-generated demand through practice audits and by publishing the results achieved by different doctors. Audits can weed out the fraudsters, and performance information can help patients make informed decisions rather than simply accept whatever a doctor tells them. Such systems exist in other countries; they are long overdue here.

Whether we use savings accounts and co-payments or rely on audits and better patient information, or some combination of these, we are still likely to produce a better outcome than by returning to the fatal conceit that government planners always know best. After decades of failed central planning, it is time to see if market forces can produce a better outcome.

## Endnotes

- 1 F. A. Hayek, *The Fatal Conceit: The Errors of Socialism (The Collected Works of F. A. Hayek)*, ed. William Warren Bartley (Chicago: University of Chicago Press, 1988).
- 2 Productivity Commission Health Workforce Study and Australian Medical Workforce Advisory Committee.
- 3 Bob Birrell, 'Medical Manpower: The Continuing Crisis,' *People and Place* (1996) 4:3, [eprints.monash.edu.au/pnp/free/pnpv4n3/birrell.htm](http://eprints.monash.edu.au/pnp/free/pnpv4n3/birrell.htm) (Accessed 9 February 2009).
- 4 ABS, *Selected Health Occupations Australia*, 2006, [www.abs.gov.au/ausstats/abs@.nsf/mf/4819.0](http://www.abs.gov.au/ausstats/abs@.nsf/mf/4819.0), (Accessed 9 February 2009).
- 5 Catherine M. Joyce, John J. McNeil, and Johannes U. Stoelwinder, 'More doctors, but not enough: Australian medical workforce supply 2001–2012,' *Medical Journal of Australia* (2006), 184:9, 441–446, [www.ncbi.nlm.nih.gov/pubmed/16646743](http://www.ncbi.nlm.nih.gov/pubmed/16646743) (Accessed 9 February 2009).
- 6 As above.
- 7 Natasha Wallace, 'Intern glut "risks patient care,"' *The Sydney Morning Herald*, 26 August 2008.
- 8 Alison Wolf, 'What's up, doc?' *Prospect* June 2008, [www.prospect-magazine.co.uk/article\\_details.php?id=10185](http://www.prospect-magazine.co.uk/article_details.php?id=10185) (Accessed 9 February 2009).
- 9 Commonwealth Government, 'Review of Australian Higher Education: Final Report' 17 December 2008, [www.deewr.gov.au/HigherEducation/Review/Pages/ReviewofAustralianHigherEducationReport.aspx](http://www.deewr.gov.au/HigherEducation/Review/Pages/ReviewofAustralianHigherEducationReport.aspx), (Accessed 9 February 2009).
- 10 Natasha Wallace, as above.
- 11 COAG Intergovernmental Agreements, [www.coag.gov.au/coag\\_meeting\\_outcomes/2008-11-29/attachments.cfm#attachmanta](http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmanta) (Accessed 9 February 2009).
- 12 As above.
- 13 The COAG process takes a step in this direction. The 73 new specialist places are designated for the private sector.
- 14 Steven Schwartz, 'Saving Australia's Healthcare System: Nostrums or Cures?' *Policy*, Autumn 1999.