

nabhealth

the changing face of the healthcare industry

a special report about trends
in the medical specialists field
by NAB Health

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introduction

This report looks at the challenges, opportunities and trends for six types of medical specialists:

- Ophthalmologists
- Radiologists
- Cardiologists
- Anaesthetists
- Gastroenterologists
- Ear, nose and throat (ENT) specialists

Commentary in this report draws on data prepared by Access Economics in 2008, which looked at medical specialties' contribution to Australia's gross domestic product (GDP) and projected numbers of doctors practising in the medical specialties listed above out to 2038. The report also includes case studies from three medical specialists.

This report shows that new trends facing medical specialist professions are having a significant effect on the shape of these fields:

- Training opportunities for specialists are reducing, while at the same time, demand for specialists is increasing.
- Women are increasingly becoming medical specialists, which is re-shaping many medical specialist professions.
- New technologies are increasing specialists' ability to provide outstanding medical care, but at the same time the cost of providing specialist medical services is increasing.

These trends are putting pressure on both the private and public medical spheres.

section 1

contribution to Gross Domestic Product

In 2007, individual medical specialist fields made the following contribution to Australia's gross domestic product (listed in order from the highest to the lowest contribution to GDP):

- Anaesthetists contributed \$2.5 billion to GDP, representing 0.24 percent of Australia's total GDP.
- Radiologists contributed \$1.35 billion to GDP, representing 0.13 percent of Australia's total GDP.
- Gastroenterologists contributed \$670 million to GDP, representing 0.06 percent of Australia's total GDP.
- Ophthalmologists contributed \$620 million to GDP, representing 0.06 percent of Australia's total GDP.
- Cardiologists contributed \$490 million to GDP, representing 0.05 percent of Australia's total GDP.
- ENT specialists contributed \$330 million to GDP, representing 0.03 percent of Australia's total GDP.



section 2

number of practitioners in the field

male medical specialists

- Male ophthalmologists: there were 636 in 1995; 560 in 2008, with 581 full time equivalents; in 2038, total number of male ophthalmologists is expected to be 655 or 672 full time equivalents.
- Male radiologists: there were 843 in 1995; 1,136 in 2008 with full time equivalent numbers being 1,180; in 2038 there is expected to be 1,566 male radiologists or 1,626 full time equivalents.
- Male cardiologists: there were 421 in 1995; 506 in 2008 or 620 full time equivalents; in 2038 this figure is expected to be 1,094 male cardiologists or 1,340 full time equivalents.
- Male anaesthetists: there were 1,513 in 1995; 2,119 in 2008 or 3,191 full time equivalents; in 2038 there is expected to be 2,990 male anaesthetists or 4,694 full time equivalents.
- Male gastroenterologists: there were 322 in 1995; 641 in 2008 or 720 full time equivalents; by 2038 this figure is expected to be 1,201 male gastroenterologists or 1,349 full time equivalents.
- Male ENT specialists: there were 300 in 1995; 337 in 2008 or 363 full time equivalents; by 2038 this figure is expected to be 671 male ENT specialists or 724 full time equivalents.

female medical specialists

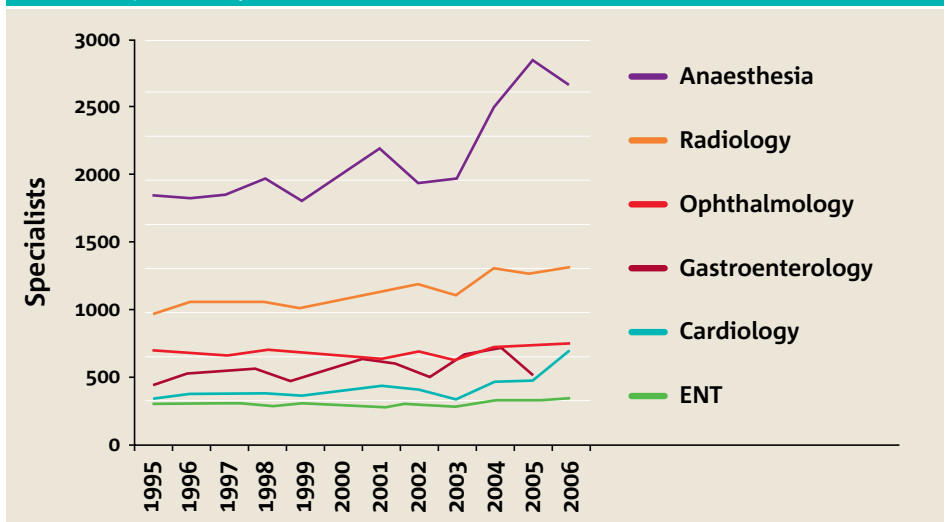
- Female ophthalmologists: there were 71 in 1995; 108 in 2008, with full time equivalent numbers equalling 88; in 2038, the total number of female ophthalmologists is expected to be 311 or 253 full time equivalents.
- Female radiologists: there were 135 in 1995; 357 in 2008, with full time equivalent numbers being 304; in 2038 there is expected to be 797 female radiologists or 679 full time equivalents.
- Female cardiologists: there were 27 in 1995; 43 in 2008; and in 2038 this figure is expected to be 147 female cardiologists or 147 full time equivalents.
- Female anaesthetists: there were 333 in 1995; 633 in 2008 or 784 full time equivalents; in 2038 there is expected to be 1,617 female anaesthetists or 2,086 full time equivalents.

- Female gastroenterologists: there were 23 in 1995; 110 in 2008 equalling 101 full time equivalents; by 2038 there is expected to be 497 female gastroenterologists or 455 full time equivalents.
- Female ENT specialists: there were 11 in 1995; 21 in 2008 or 18 full time equivalents; by 2038 there is expected to be 137 female ENT specialists or 120 full time equivalents.

Access Economics calculates that between 1995 and 2005 the medical specialist workforce grew by 3.3 percent per annum, from a base of 2.4 percent of the health labour force.

The specialties with the highest growth rate are cardiologists, gastroenterologists and anaesthetists.

Growth in specialists by field, 1995-2006



Source: AIHW (2008b)

section 3

industry trends

There has been a marked increased in the number of migrant medical specialists

income

Access Economics' report notes "specialists generally have higher incomes than GPs. For example, a GP's Level B consultation has a standard fee of \$33.55, while a non-GP specialist's referred consultation has a standard fee of \$79.05; which is 2.36 times the GP fee." In 2003 Metherell¹ reported average specialist incomes in excess of \$200,000 per annum, with anaesthetists earning \$232,347 per year net income on average. According to Access Economics' data medical specialists receive real income growth of 1.75 percent annually.

hours

Access Economics reports that between 2001 and 2005, specialists' average hours fell from 47 to 46 per week.

training

Education for medical specialists is a long process consisting of a university qualification as well as practical training. The practical training begins in the hospital system where a typical residency is two or three years. After this, a graduate is a qualified doctor eligible to practice within the hospital system.

Most will elect to continue their training in a specialty, either as a GP or in another field. The past six years has seen a steady increase in the number of medical students finishing initial training and then choosing to specialise. The largest growth has been in anaesthetics, surgery (including cardiology and ENT) and radiology.

migrant specialists

There has been a marked increased in the number of migrant medical specialists, with Access Economics' figures showing the number of medical specialists entering the country jumping from 73 in the 2002-2003 financial year to the 390 in the 2006-2007 financial year.

¹ Metherell M (2003) 'Doctors furious as incomes laid out', Sydney Morning Herald, 12 September.

case study 1

Dr Andrew Brooks

Urologist

Sydney-based urologist Dr Andrew Brooks identifies the balance between the need to provide outstanding patient care, the politicised nature of health care and changing technologies as some of the key challenges facing his industry sector.

Dr Brooks believes: “progress in medicine often means progress in technology. The requirement for capital to finance technology creates a new dynamic in the patient doctor relationship. One cannot provide the quality of treatment and outcomes possible if the technology is not available.”

“The results of treatments are as dependent on government or the private sector providing the resources as they are on the skill training and professionalism of the health care team. Increasingly the provision of this technology is becoming an issue particularly in the public sector. The private sector is also not immune, as profit and the provision of expensive resources to improve outcomes are not always compatible.”

According to Dr Brooks “the doctor as the patient advocate for quality outcomes is often in conflict with the providers of the capital who must distribute the limited resources. The issue confronting the profession and the industry is to establish mechanisms to work together to ensure that the money is allocated to produce the best balance between capital expenditure and outcomes.”

Dr Brooks says,

“the public sector, particularly in NSW, is chronically underfunded in proportion to the number of people who seek access to the service.”

Changes that influence the numbers of people who have health insurance allowing access to the private health sector place an increasing burden on the public sector. It is very distressing for doctors as well as the patient and families to be confronted with long waiting lists for so called elective surgery. One will have to wait to see whether the recent changes to health care rebates will affect insurance rates.”

Another issue Dr Brooks identifies is staffing. “There is a shortage of both doctors and nurses in the world. In Australia the shortage is compounded by government decisions a decade ago to reduce the number of graduating doctors. The problem has been addressed by increasing the number of graduating doctors but this change will need a decade to fully populate the ranks. In the short term we are recruiting lots of international medical graduates. While it may help us in a world short of doctors this clearly has other effects.”

“The manpower issue is further compounded by the demand for better work life balance among the younger doctors and the feminisation of the workforce. Women in the medical workforce face the challenge of family life and a medical life which is not easy to regulate. Whilst home help and parents may ease the load, the sick child or the need to be at a certain place at a certain time creates stress and often involves a decision to limit one’s involvement in clinical practice to be more available,” says Dr Brooks.

Another challenge is training. Dr Brooks says “training in surgery is essentially a pro bono job undertaken by surgeons in an apprenticeship type model. It is an essential part of being a professional in surgery as there is no other mechanism for teaching and training. The challenge for us is to become more efficient as educators to teach and train to lessen the time taken to achieve the necessary skills and knowledge to operate independently.”

Dr Brooks says, “I find medicine – and surgery in particular – interesting, challenging and very rewarding. I don’t lay awake at night wondering if life has any meaning. However medicine is a demanding mistress and one can easily lose the balance in life. To keep the balance between physical health, personal relationships and financial security while trying to service out-of-hours rosters and essentially 24 hour on call commitments to hospitalised patients and maintain current knowledge is often difficult.”

case study 2

Dr Sonja Latzel

ENT Surgeon

As the only female ear, nose and throat surgeon in South Australia, Dr Sonja Latzel occupies a unique position in the medical community. Although she had no female role models to turn to while she was undertaking her training, she says “I had no sense of obstruction from male practitioners – they were all very supportive.”

The biggest challenge Dr Latzel faced while she was learning her craft was getting access to training opportunities. “More people are coming through med school and there is more need for specialists, but there are fewer training opportunities in hospitals,” says Dr Latzel. This means it’s harder to get the required hours up to practise as a specialist.

It’s now the norm not only to acquire a specialty, but also to acquire a sub specialty. In ENT, sub specialties exist in ear or sinus surgery, or in head and neck cancer, for example. To become a sub specialist, overseas training is essential. But for most women, undertaking overseas training is especially difficult, particularly if their partner is also a professional with their own career pressures.

“I trained in the UK and US; my husband is a surgeon who is originally from the UK. He was with me for part of my training and I did some overseas training without him. But for many women, it’s very difficult to leave their partner to go overseas to train. It’s equally difficult for partners to drop everything and move overseas while their wife undertakes specialist training,” she says.

Dr Latzel says in Australia, a national market for training has partially addressed this issue, opening up opportunities for specialists to train outside their home state. But there is now decreased opportunity for Australian specialists to train in the UK, where they traditionally received specialist training, as places often go to doctors from the European Union rather than to Australian trainees. On top of this, many training places are unpaid. This can make it virtually impossible for Australian doctors to receive adequate training in their specialty or sub specialty.

Many female specialists also struggle to combine their work with a family life. “People are usually around 33 when they finish their training, which is the end of the major part of a woman’s fertile life. Then there’s the expectation to go overseas to train at around the age of 35 or 36. Many female doctors can only take five or six weeks off work to have a baby.

You might be training 60 hours a week and studying on top of that, so to have a newborn as well is virtually impossible.

Many female doctors have to have IVF or adopt or only have one child,” she says.

Dr Latzel says medicine needs women in the profession to ensure there is a full surgical workforce. “Fifty percent of med graduates are women and there needs to be more flexibility in training to respond to this,” she says, while acknowledging that the introduction of more humane working hours also means a decrease in the exposure to patients.

Dr Latzel points to the US model as a possible alternative to the Australian model. In the US young doctors are streamed from early in their career into surgical and non-surgical streams, but she says there are also limitations to this model “because you’re managing a whole patient, not just the surgical side of things.”

While the increasing use of surgical simulators, practice using cadavers and the use of plastic bones in training will go some way to addressing the training issue, Dr Latzel says there also needs to be more opportunity for young surgeons to train on real patients in Australia.

case study 3

Dr Evelyn Yap

Radiologist

Adelaide-based radiologist Dr Evelyn Yap believes practices in the medical profession are slowly becoming more humane and are changing to accommodate the considerable increase in the number of female doctors now practicing across Australia.

“People used to work 24 or 36 hours straight which is really not sustainable. But now some hospitals have night registrar reporting; you might work four nights a week and be able to rest during the day. Some hospitals also offer job share training by negotiation, but this of course doubles the training time, which is hard to manage if you also want to have a family,” says Dr Yap.

“Eventually the continuing shortage of certain specialties will force change”

“In Western Australia there is a shortage of radiologists and so some hospitals and practices are offering school hour shifts from 9.00 am to 2.00 pm,” she says.

Dr Yap says some medical specialties, including her own field of radiology, are more attractive than others to female doctors because the nature of the work makes them more conducive to balancing work and family commitments.

“In radiology the hours are usually 8.30 am to 5.00 pm and when you have finished for the day, there’s really no follow up needed as in other medical fields. It’s also possible to work two or three days a week in radiology. Time-wise it’s a better lifestyle than many medical fields, which means you can work and also have a family,” she says.

“It’s true interventional radiology requires follow up, but usually only for one or two days. And if patients turn up at emergency and need an x-ray, there’s always someone on call you will be very busy, but you know when that will be and can manage your life around it.”

Dr Yap says other fields that are attractive to women because of the nature of the work include dermatology and ophthalmology. “These are extremely popular fields for women because there’s really no such thing as an emergency. But they are also extremely popular and difficult to get into,” she says.

Aside from the feminisation of certain medical fields, Dr Yap says some medical specialties are popular because of their remuneration potential. She says dermatology and ophthalmology are two such fields, as well as orthopaedics and radiology.

“Cosmetic surgery is also becoming more popular as a specialty, with specialist plastic surgeons and now GPs working in this area. Timewise, plastic surgery offers a good lifestyle and the returns are also good.”

Dr Yap says the financial potential of many medical specialties has not gone unnoticed by the new large corporate groups that offer a range of medical services from one location. “These corporations are really changing the face of medicine, we’re even starting to see corporatised groups of surgeons now. But I don’t necessarily think this is a good way to go. You can’t run a radiology practice like a fish and chip shop. At one stage there was a big swing towards corporates but I think now doctors are actually starting to turn away from these groups,” she says.

Says Dr Yap, “You might find someone signs a five year contract with a corporation, and after five years decides to set up on their own. Often the contract includes a caveat that the doctor can’t set up within a certain radius from the corporate practice, but in radiology this doesn’t happen as much as in other fields. Young radiologists are also setting up on their own because they don’t like the working conditions of the corporate practices.”

about the research

This report is designed to shine a light on current practices of medical specialists in Australia.

Most of the data contained in this report was prepared by Access Economics in 2008, which was commissioned by NAB Health to:

- Estimate the value in dollars and as a share of GDP of the healthcare industry as a whole.
- Estimate the current number of people and full-time equivalent people by gender in the workforces of medical specialists.
- Estimate changes in average income among medical specialists.

Data was also obtained from interviews with three medical specialists Dr Andrew Brooks, Dr Sonja Latzel and Dr Evelyn Yap.

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