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Too Many GPs

Bob Birrell

MONASH University
Arts

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Summary

The federal and state governments base their GP manpower policies on the assumption that there is a shortage of GPs in Australia, particularly in non-metropolitan areas.

This assumption is founded on a mindset that dates from the mid-2000s when there really was a shortage of GPs in some of these areas. There is a formidable bureaucracy and powerful vested interests with a stake in preserving the shortage story.

However, with a few exceptions, mainly in remote areas, it is wrong. There has been a sharp increase in the number of Full-Time-Work-Equivalent GPs (FWE GPs) billing on Medicare since the mid-2000s. The level of GP services in both metropolitan and non-metropolitan is well above that considered by medical manpower authorities in the past to be adequate. This over-servicing is showing up in high bulk-billing rates. By 2011-12 these were more than 80 per cent in both metropolitan and non-metropolitan areas.

Another indicator of the change is the number of GP services billed per person per year in Australia. This increased from 4.9 in 2004-05 to 5.7 in 2011-12.

The oversupply is about to get worse. The number of fully registered Australian-trained GPs who will enter the GP workforce will double to around 1,000 per year over the next few years. Most will locate in metropolitan areas because they can practise wherever they chose. In so doing, they will add to the over-servicing problem. They can do so because patients who are bulk-billed face no financial constraint on their consumption of GP services and GPs make the judgements about what services are needed.

GP over-servicing is very expensive for the Australian taxpayer. In 2011-12 the Commonwealth Government paid out $6.7 billion to GPs billing on Medicare and for GP incentive programs. This amounts to an average of $317,000 for each of the 21,119 FWE GPs billing on Medicare in 2011-12.

The emphasis of Government medical manpower policy should switch to ensuring that the GPs serve where they are needed. Part of the solution must be to restrict the right to practise in over-serviced areas.

This is not equivalent to the conscription of doctors. The Government can limit the places where GPs are permitted to practise through its controls over the issuance of Medicare provider numbers. This already happens with GPs who are IMGs. They are only issued with provider numbers if they serve in districts of workforce shortage. All that would be required to limit over-servicing in metropolitan or any other locations would be to not issue additional provider numbers in such areas until the oversupply situation ends.

In the case of policy regarding IMGs, the recruitment of IMGs on limited registration into districts of workforce shortage should cease. Surveys of morbidity indicate that regional communities require more medical service per person than do metropolitan communities. The demands on GPs skills are also greater in these communities because GPs are often required to provide procedural services in local hospitals as well as GP clinical services. Regional GPs also do not have the same access to specialist back-up as do GPs in metropolitan areas. It would be far preferable if the impending surge of highly trained and accredited local GP registrars served in shortage areas when they complete their training.

There is no need for more limited-registration IMGs, yet the numbers being sponsored on 457 visas is surging — reaching 2,663 in 2011-12. This reliance is now built into the business model of some corporate employers. One of these, Tristar, had established 40 clinics in regional Australia by 2012, all heavily reliant on the employment of IMGs on 457 visas.

Too Many GPs

Introduction

In late 2011 the Centre for Population and Urban Research [CPUR] published a report entitled *Australia's New Health Crisis – Too Many Doctors*.[1] The report was based on information up to the year 2008. The focus was on General Practice and the conclusion was that Australia was 'awash with doctors'. It was a conclusion that contrasted starkly with the dominant official view that Australia continues to face a shortage of GPs, mainly in non-metropolitan areas. This is subsequently referred to as the 'doctor shortage' story.

The decision to revisit this issue was prompted by the release of the 2011 Census. This showed that the number of persons employed as General Medical Practitioners (GPs) in Australia had grown from 35,453 in 2006 to 43,430 in 2011, an increase of 23 per cent. Over the same period Australia's population grew by 7.8 per cent. This is just a rough indicator of recent trends, because it includes doctors working in general practice as well as in hospitals. It also does not take account of the hours these doctors work. Nevertheless, the implication is that Australia must be even more 'awash' with doctors than reported earlier. Much of this growth in GP employment came from a huge influx of doctors from overseas since 2006 (see Table 3 below).

As we will see, the official view is that GP shortages remain and that Australia continues to need an influx of International Medical Graduates (IMGs) who have completed their training overseas. This is despite the fact that, as shown in Table 3, thousands of these IMGs are not employed as doctors. Their situation has worsened with the looming torrent of domestically trained medical graduates. These local graduates are occupying the junior hospital jobs that many IMGs had been able to use to get a foot into the door of medical practice in the past.

The torrent of domestically trained doctors is detailed in Table 1. About one third are choosing to enter general practice. All domestic graduates must do some form of specialist training leading to a Fellowship in their field before they are allowed to practise without supervision. General Practice is one of the possible specialist areas that they can choose. By 2011, such was the demand for places in the General Practice training program (from Australian-trained graduates and IMGs) that hundreds missed out on places. This is notwithstanding the rapid increase in the number of places in the first year of the General Practice training program from 617 in 2009 to 1,000 in 2012).[2]

Table 1: Domestic and overseas students graduating from medical schools, Australia, 2004-2011

	Domestic	Overseas	Total
2004	1,287	216	1,503
2005	1,320	267	1,587
2006	1,335	288	1,623
2007	1,544	316	1,860
2008	1,736	401	2,137
2009	1,915	465	2,380
2010	2,259	474	2,733
2011	2,507	457	2,964

Source: Medical Deans Australia and New Zealand, 2012, *Medical Student Graduates (1999-2011)*

How many GPs does Australia need?

There is no widely agreed benchmark as to how many GPs are needed in Australia. Any such judgement must take into account a variety of factors, including an increase in the share of GPs who work part-time as more female doctors enter the GP workforce.

Before it was disbanded in 2006, the Australian Medical Workforce Advisory Committee (AMWAC) conducted several inquiries into GP workforce needs which took account of what the Committee thought was the appropriate level of GP service availability. AMWAC was an advisory committee which reported to the Australian Health Minister's Advisory Council. It was relatively independent of the government of the day, and its members were drawn from experts in the health fields.

Behind AMWAC's views about the appropriate size of the GP workforce was a judgement that, if there were too many GPs, this would prompt over-servicing as doctors chased revenue. Conversely, if there were too few GPs, potential patients would have to queue for service.[3]

Needless to say, it was a tricky business translating this criterion into an appropriate number and distribution of GPs. In its 2002 report, AMWAC decided that the actual level of GP servicing in Large Rural Centres represented the appropriate standard. A major factor in this choice was the level of bulk billing for GP services in these Centres at the time. In 1998-99 this was 60.2 per cent.[4] This level of bulk billing was taken to indicate that GPs were experiencing much less competitive pressure (to keep their service level up) than was the case in capital cities. At the time, the level of bulk billing in capital cities was 85.6 per cent.

On this basis, AMWAC concluded in 2002 that there was a surplus of GPs in capital cities, a shortage in Rural and Remote areas, but that the number was just right in Large Rural Centres.

AMWAC revisited the GP workforce situation again in 2005. It reaffirmed the 2000 judgement.[5] Its policy conclusions were similar to those in the 2002 report, that is, there were too many GPs in metro areas and not enough in regional areas outside Large Rural Centres.

By the time AMWAC was disbanded, the political situation regarding GP numbers had changed. As detailed below, public concerns about GP shortages had mounted such that, from the Australian Government's point of view, it had become an urgent priority to get more GPs into the field, especially in regional areas. As we will see, successive Commonwealth Governments have put in place a raft of policies designed to increase the number of GPs to ensure that more serve in non-metropolitan areas.

This shortage mindset, and the policies it prompted, prevails to this day. This has meant that, as long as there continues to be evidence that there are fewer Full-time Work Equivalent (FWE) GPs in non-metropolitan areas than in metropolitan areas, such evidence is enough to confirm the 'doctor shortage' story. (The FWE GP measure adjusts for the hours GPs are estimated to work such that they equate to a measure of GPs who work full-time).

This paper challenges the current shortage mindset. It argues that according to the AMWAC criteria, there is no longer a shortage of GPs, and that the large scale importation of overseas-trained IMGs should cease.

Background to this study

CPUR and others have written at length about the twists and turns of Australian Government policy on medical manpower during the 1990s and early 2000s (described below). The motivation to revisit the GP situation in 2011 derived from information provided by the Rural Doctors Association of Victoria (RDAV). The members of this group were concerned about the rapid increase in the number of IMGs being employed in entrepreneurial practices set up in regional locations in Victoria. Most of these IMGs held 457 visas (which required them to stay in their sponsor's employment) and were registered by the Medical Board of Australia on a limited basis. The conditions specified under this limited registration are discussed below.

One particular organisation, Tristar, had established 29 such practices across regional Victoria towns by 2011.[6] Currently Tristar appears to have about 40 practices, including 11 in NSW and one in Canberra.[7] Tristar is now one of the four main corporate players in the GP market in Australia (the others are Primary Health Care, IPN and Healthscope).[8]

The RDAV thought that this influx of IMGs in the Tristar chain was not a manifestation of a shortage of GPs in regional areas. Rather, it reflected the potential gain which entrepreneurial practices could reap through employing IMGs on temporary work visas. They could employ IMGs on wages and conditions which would provide such practices with a competitive advantage over established GP practices. Basically these new entrepreneurial practices were vacuuming up routine medical services by offering bulk-billing at extended hours. This was possible because the Medical Board of Australia was allowing such doctors to bill on the Medicare system while they were still on limited registration with the Board.

The RDAV was particularly concerned that these arrangements were allowing such doctors to practise with low levels of supervision (often by telephone). This was far less than is required for registrars enrolled in the post-graduate GP training program. Also, when registrar GPs in training are dealing with patients, they have to say they are in training. The non-specialist IMGs with limited registration do not.

In addition, most IMGs on limited registration have not been subject to any significant independent Australian assessment of their clinical skills. This is a concern which CPUR has written about for years.[9] The Medical Board of Australia is presiding over a double standard regarding assessment of medical skills. All Australian graduates are required to undergo a rigorous postgraduate training program during which they work under close supervision of GPs who have been accredited as supervisors, and, as indicated, are required to declare their status as being in training. GP registrars also have to complete a set of examinations successfully before being granted a GP Fellowship. Only then can they practise as independent GPs and their patients have access to full Medicare rebates.

The perception of doctor shortages and the policy response

Views about the supply of doctors have waxed and waned. Through the 1990s, the official perception was that there were too many doctors. Successive Labor and Coalition governments sought to restrict supply. The main concern was the rapid increase in the cost of GP services billed on Medicare at the time. This was occurring in a context where the number of GPs was growing rapidly, largely because of the influx of IMGs.

The most decisive action reflecting these concerns was taken by the Coalition Government in 1996. The Government put in place new legislation requiring that all new domestic graduates wanting to be GPs had to first complete postgraduate studies in general practice before they could practise independently and bill on the Medicare system. The Government also put a restrictive quota on the number of training places in this postgraduate GP program. In the case of IMGs, they were not allowed to bill on the Medicare system until 10 years had elapsed after they gained full registration as GPs in Australia. This provision could only be waived if the IMG agreed to serve in an 'area of need', the definition of which was left to the various State Government Health authorities.

These restrictions came under pressure by the early 2000s because they were contributing to GP shortages, particularly in non-metropolitan areas. These shortages set the political alarm bells ringing as regional communities began complaining about staff vacancies in local hospitals and GP practices. Another manifestation, which also helped to set the political antennae flapping, was that the share of GP services being bulk-billed had fallen well below that applying in metropolitan areas.

In 2004, the Coalition Government (Tony Abbott was then Minister for Health) decisively changed its stance. Australia was declared to have a shortage rather than a surplus of doctors. One outcome was an increase in domestic medical training, which led to the striking increase in graduate numbers shown in Table 1. The Coalition Government also reversed its stance on IMGs. It kept the 'area of need' designation but now encouraged the states to recruit more IMGs (mainly from overseas). Substantial resources were invested in setting up state-based rural recruitment agencies tasked to select IMGs for private and hospital practice in regional areas.

The Coalition also turned a blind eye to increasing concern within the medical fraternity about the growth in the numbers of IMGs being permitted to practise with limited registration, whether in private practice or as hospital medical doctors. The priority of recruiting more doctors trumped concerns about quality of service.

By the time CPUR reviewed the medical manpower situation in 2011, there had been some tightening of the rules governing whether IMGs could practise under limited registration. Since 2008 (except for doctors qualified in major English-speaking countries) those recruited to 'area of need' locations had to first pass a test of medical knowledge. They are now subject to an interview regarding their clinical skills. This interview falls well short of the rigorous assessment of clinical skills which domestic GP registrars must pass and of the clinical assessment which the Australian Medical Council administers prior to allowing IMGs to gain full registration in Australia. The Medical Board also now limits the time an IMG can practise on limited registration. This registration is supposed to lapse after three years if the IMG does not make significant progress in obtaining their GP fellowship.

Thus, there remains a double standard between the requirements faced by domestic graduates (and the IMGs who have entered the postgraduate GP training program) before they are permitted to practise and the requirements faced by IMGs who have been granted limited registration. Nor has there been any move to limit the number of IMGs practising on these terms — quite the contrary. As shown below, their numbers continued to increase.

Recent official reviews of the GP workforce

In August 2012 the Senate Community Affairs References Committee published its review of *The Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas*. The Committee concluded, on the basis of submissions from all the interested parties, that: 'there needs to be a significant increase in rural generalist GPs'.[10] This did reflect growing calls for rural GPs to be better trained as 'rural generalists' to meet the demands of isolated practice. The Committee dismissed the CPUR's claim that 'Australia is awash with GPs' without examining the evidence on which it was based. The Committee went on to say that;

> *Dr Birrell's findings were not supported by other submitters to the inquiry. The view expressed by the National Rural Health Alliance Inc. is representative of the majority opinion that argued that there is a shortage of medical professionals in regional areas, even if there are a sufficient number of professionals in Australia overall.*[11]

It should be no surprise that the Committee reached this conclusion. The notion that there is a regional shortage of doctors is an article of faith within the medical manpower industry. As indicated, this has been the basis for Australian Government policy over the past decade. From the point of view of the politicians and bureaucrats involved, there are more risks in understating the need for doctors than overstating them. The costs of providing for the extra doctors is borne by the taxpayer and buried in the budget. Doctor shortages, however, tend to be focussed locally and to generate real political heat. Also, no politician or bureaucrat wants to acknowledge that the quality of medical care may be being compromised by the employment of numerous IMGs on limited registration.

Many of the organised interest groups expressing views on the issue have vested interests in maintaining the shortage myth. Chief among these are the medical recruitment agencies, including the Rural Health Workforce Australia, whose business is to recruit IMGs to 'areas of need'. The thousands of IMGs in Australia who lobby to relax the rules that they confront in gaining full registration also have a strong interest in perpetuating the shortage story.

The shortage mindset also continues to shape Skills Australia's decision to include GPs and specialists on its Skills Occupation List (SOL). This list is used in the selection of permanent immigrants. Applicants with occupations not listed on the SOL are ineligible to apply for visas under the Government's permanent-entry points-tested immigration skill categories. Skills Australia is now known as the Australian Workforce and Productivity Agency (AWPA). In 2012, AWPA decided again to keep GPs and other medical specialists on the SOL.

HealthWorkforce Australia

The final and most important word on the medical manpower situation has come from HealthWorkforce Australia. This is a new federal government agency (with far less independence from Government than was the case for AMWAC) whose tasks include setting the overall parameters for official health workforce policy. Its 2012 report, *Health Workforce 2025,* presented in three large volumes, details the results of its empirical assessment of the supply and demand situation for doctors and nurses in Australia. This is presented along with modelling designed to provide policy makers with an informed outlook on the future supply and demand situation. The report claims to provide 'Australia's first major, long-term, national projections for doctors, nurses and midwives and presents the best available planning information on our future health workforce'.[12]

Health Workforce 2025 concludes that, in the case of GPs, there is a significant shortage and that in the light of this shortage the Government should not limit the flow of IMGs into the GP workforce. It concludes that 'if recent trends in supply and expressed demand continue' these shortages will be sustained.[13] It asserts that any move towards a more self-sufficient policy on GPs — which it acknowledges is favoured by the Council of Australian Governments (COAG) (to whom HealthWorkforce Australia reports) — would have to be accompanied by major reforms in the way the GP workforce is allocated.[14]

The basis for the shortage claim is that there continues to be fewer GPs to population in non-metropolitan areas than in metropolitan areas. *Health Workforce 2025* bases this judgement on a 2009 Australia Institute of Health and Welfare (AIHW) Medical Labour Force Survey report. This 2009 report states that the ratio of FWE GPs per 100,000 people is far higher in major cities than it is in other areas.[15]

This is not the current position of AIHW. Its *Medical Workforce 2010* report (summarised in Table 2) shows that there is no difference in the number FWE GPs per 100,000 people working in the major cities, inner regional and outer regional areas of Australia. The exception is the Remote/Very Remote area. The AIHW advises readers that the latter finding (that the Remote/Very Remote area is even better served than Major Cities) is likely to be an anomaly deriving from the way the statistics were collected.[16]

Table 2 does show a much higher 'Hospital non-Specialist' density in major cities. This reflects a far higher concentration of hospitals in metropolitan areas, largely because state governments have decided to locate specialist treatment in these areas. But, as indicated, there is no difference in the density of General Practitioners to population in the major cities and other areas.

Table 2: Employed medical practitioners by region by FWE GPs per 100,000 of the Australian population, 2010

	Major Cities	Inner Regional	Outer Regional	Remote/Very Remote
General Practitioner	105.2	105.6	104.5	134.2
Hospital non-Specialist	41.7	18.7	14.3	57.3

Source: Australian Institute of Health and Welfare, *Medical Workforce 2010*, pp. 26-29

The AIHW 2010 is not the last word on this issue. Later in this paper more recent data on the distribution of GPs is shown. This information is drawn from official Medicare statistics which were published in January 2013 in the Productivity Council's *Report on Government Services 2013*. Its findings, which include data for 2011-12, indicate that though the number of FWE GPs per 100,000 of the population in non-metropolitan areas is converging on that in metropolitan areas it has not yet reached this level. The explanation for the differences in the two reports is that the data are drawn from different sources. The AIHW's 2010 report is based on a survey of GPs at the time they were required to register with the Medical Board of Australia. The Productivity Council figures are drawn from Medicare records.

The Medicare records indicate that, notwithstanding the lower level of GP numbers in non-metropolitan areas, there has been strong increase in the number of FWE GPs in non-metropolitan Australia, as well as a striking increase in the proportion of the GP services delivered which are bulk-billed. This increase is such that, as is argued below, it undermines *HealthWorkforce 2025's* shortage

claims. Before returning to this issue, further background about the IMG presence in Australia is provided.

The IMG presence

Health Workforce 2025's modelling of the future need for GPs significantly understates the IMG present in Australia. All of its modelling scenarios, except for the one assuming a move towards self-sufficiency from domestic sources, incorporate immigration assumptions that are outdated and contain significant underestimates. These scenarios assume that the influx of permanent-resident GPs will be 780 a year and that the number of temporary-resident IMGs will remain unchanged from the current 'pool of [IMG] GPs who are already in the workforce. This was held constant over the projection period.'[17] This pool number is put at 1,145. Yet the number of IMGs on limited registration with the Medical Board of Australia alone is way above this number (see below).

In the case of permanent migrants, the actual number of permanent resident visas issued to principal applicants who were GPs under the government's skilled programs was 713 in 2010-11 and 909 in 2011-12. There would have been hundreds more GPs who entered Australia from New Zealand or through the rest of the permanent-entry program — especially via family reunion.

In the case of temporary migrants who were GPs, their numbers have surged recently. In 2010-11 the number of 457 visas issued to principal applicants who were GPs was 1,119. Another 1,233 visas were issued to GPs who were recruited for positions in hospitals as Resident Medical Officers. In 2011-12 the numbers in these two categories rose to 1,407 and 1,256 respectively.[18]

These numbers indicate that *Health Workforce 2025* assumptions about the size of the pool of temporary migrant GPs will not change over time is incorrect. The latest registration data available from the Medical Board of Australia are dated 29 January 2011. They indicate that at this time there were 6,424 IMGs with limited registration in Australia who had not yet qualified for general or specialist registration. Of these, 2,731 were registered to practise in an 'area of need' location. Almost all would be GPs. An unknown, but undoubtedly very large, number of the rest would have been doctors serving as Resident Medical Officers, many of whom harbour hopes of eventually obtaining the qualifications needed to practise as GPs.

In addition, the stock of IMGs in Australia anxious to gain medical employment is growing rapidly. Most of those who hold 457 visas seek to stay in Australia. As well, there is a large number of IMGs who, as noted, have entered Australia via family reunion, New Zealand and other routes. Most of these medically qualified migrants want to gain employment as GPs. Many of them are currently trying to access intern positions and postgraduate GP training places in order to gain the qualifications needed for full registration as a GP in Australia.

Table 3, which is drawn from the 2011 Census, indicates the size of this pool. It shows that, as of August 2011, there were 11,080 overseas-born persons who had arrived in Australia since the beginning of 2006 whose highest qualification was a degree or higher qualification in Medical Studies. That is an average of nearly 2,000 a year, more than double the annual number of domestic medical graduates.

However, as Table 3 also shows, 1,527 of these medically qualified migrants were in occupations other than medicine and 2,337 were not working at all. In total, 3,864, or 34.9 per cent, were not

working as doctors. Persons born in non-English-speaking background (NESB) countries accounted for more than three-quarters of the 11,080 arrivals. More than 40 per cent of these NESB migrants were not working as doctors. They constitute a reserve army of doctors, which should be taken into account in medical workforce planning.

Table 3: Persons aged 20-64 years who arrived in Australia from 1 January 2006 to 9 August 2011 whose highest qualification is a bachelor degree or higher in Medical Studies, August 2011

	Employed persons by occupation			Not employed	Total
Country of Birth	Generalist Medical Practitioners	Other Medical Practitioners	Other occupations		
	Number				
Main English-speaking background	1,105	986	238	167	2,496
Non-English-speaking background	3,684	1,441	1,289	2,170	8,584
Total overseas-born arriving 2006-2011	4,789	2,427	1,527	2,337	11,080
	Per cent				
Main English-speaking background	44.3	39.5	9.5	6.7	100.0
Non-English-speaking background	42.9	16.8	15.0	25.3	100.0
Total overseas-born arriving 2006-2011	43.2	21.9	13.8	21.1	100.0

Notes:
Main English-speaking background countries are New Zealand, United Kingdom, Ireland, Canada, United States and South Africa.
Source: Australian Bureau of Statistics, Census 2011, Table Builder

GP numbers today

The Productivity Commission's *Report on Government Services 2013,* published January 2013, is the most authoritative recent source on the number and distribution of doctors working as GPs.[19]

Table 4 shows the number of GPs billing on Medicare and the ratio of FWE GPs to population. Alternatively, this ratio is sometimes expressed in terms of the number of people per FWE GP. (Both ratios are included in Table 4).

There was a 16.7 per cent growth in the number of FWE doctors working in General Practice and billing on Medicare between 2006-07 and 2011-12. As noted earlier, this rate of growth is far faster than the 7.8 per cent increase in Australia's population during the same period. As a result, it can be calculated from Table 4 that the ratio of FWE GPs to population improved by eight per cent between 2006-07 and 2011-12. It is also notable that this improvement has sped up over the last couple of years, no doubt reflecting the surge in the combined number of locally trained GPs and the number of IMGs being recruited from overseas.

The Productivity Commission does not provide a breakdown of the distribution of GPs by the geographical classification used in the AIHW data shown in Table 2. The split is just by urban and rural. The urban designation includes capital city and other metropolitan areas. All other areas (including large rural centres, small rural centres and remote areas) are included in the rural category.

Table 4: Full-time workload equivalent (FWE) GPs billing on Medicare and FWE GPs per 100,000 people

	FWE GPs	FWE GPs per 100,000 people			Population per FWE GP	
	Australia	Australia	Urban	Rural	Urban	Rural
2006-07	18,091	86.8	89.4	78.0	1,119	1,282
2007-08	18,613	87.9	90.0	80.0	1,111	1,250
2008-09	19,231	85.8	90.7	81.3	1,102	1,231
2009-10	19,729	89.1	90.7	81.5	1,103	1,227
2010-11	20,267	90.2	91.5	84.1	1,092	1,189
2011-12	21,119	93.9	95.3	88.0	1,049	1,136

Source: Productivity Commission, *Report on Government Services, 2013*, Tables 11A.5 and 11A.17

By 2011-12 there were 93.9 FWE GPs per 100,000 people billing on the Medicare system in Australia. Is this enough? One way to assess the numbers is to look at the average number of GP services billed on Medicare per Australian resident. In the early 2000s when the GP shortage story took hold and bulk-billing levels in non-metropolitan areas were low, the number of GP Medicare items claimed per year per head of the population was in steep decline. This number had fallen from 5.5 in 1998-99 to 5.3 in 2000-01, 5.0 in 2002-03 to 4.9 in both 2003-04 and in 2004-05. [20] However, since that time and as the measures described above kicked in, the average number of services per capita has increased, reaching 5.2 in 2007-08 and 5.7 in 2011-12.[21]

This improvement has been especially notable in rural areas, though as Table 4 shows, there remains a small and shrinking advantage for urban areas. This convergence continues the trend reported 2011 by CPUR in *Australia's New Health Crisis*.[22] Data up to 2007 were reported in that publication. The latest data available which allow for a regional breakdown are for 2010. Table 5 shows that by 2010 there was very little difference in GP availability for metropolitan and regional locations in Victoria. (The pattern is similar in other states).

Table 5: GP Workforce, Victoria by metropolitan and regional areas and Australia, selected measures, 2004, 2007 and 2010

Location of Division of General Practice	Number of Full-time Workforce Equivalent (FWE) GPs as at:			Population per FWE GP			Population per FWE GP indexed to Australian average* (1.00)		
	30/6/04	30/06/07	30/06/10	2004	2007	2010	2004	2007	2010
Australia	16,874	18,610	20,082	1,191	1,129	1,101	1.00	1.00	1.00
Metropolitan	3,220	3,530	3,875	1,167	1,125	1,096	0.98	1.00	1.00
Regional	940	1,111	1,254	1,389	1,204	1,121	1.17	1.07	1.02
Victoria	4,160	4,641	5,129	1,217	1,144	1,102	1.02	1.01	1.00
% Victoria's GP workforce which is regional	22.6	23.9	24.4						
% Victoria's population which is regional^	25.8	25.2	24.9						

* If greater than 1.00, the average FWE GP in that location in that year has more people to service than the average FWE GP in Australia as a whole. If the index is 1.02, the average local FWE GP services two per cent more people than their Australian equivalent.

If less than 1.00, the average FWE GP in that location in that year has fewer people to service than the average FWE GP in Australia as a whole. If the index is 0.98, the average local FWE GP services two per cent less people than their Australian equivalent

Source: derived from Key Division of General Practice characteristics 2004-2005, 2007-08 and 2010-11 from <http://www.phcris.org.au/products/asd/keycharacteristic/index.php>

According to the AMWAC reports cited above, the best indicator of adequacy of service (at least in access to GPs) is bulk-billing rates. AMWAC argued that where the great majority of GP services are bulk-billed this is an indicator of excess supply in which GPs have to compete for patients. By contrast, AMWAC argued that the relatively low bulk-billing rate (60.2 per cent) evident in Large Rural Centres in 1998-99 – was a sign that GPs were much less subject to this pressure.

As the ratio of FWE GPs to population has improved since the mid-2000s so has the bulk-billing rate. The Productivity Council reports that, for Large Rural Centres, the bulk-billing rate reached 71.5 per cent in 2006-07 and 78.1 per cent in 2011-12. For Small Rural Centres, the bulk-billing rate in 2006-07 was 74.3 per cent and 81.4 per cent in 2011-12. The parallel figures for capital cities in these two years were 79.4 per cent and 82.3 per cent.[23]

This improvement also reflects government actions to promote bulk-billing on the part of GPs. From January 2005, the Medicare benefit paid to a GP for almost all services, whether bulk-billed or not, was increased from 85 per cent to 100 per cent of the Medicare schedule fee. So the GP did not have to bill the patient direct to get an extra 15 per cent. It could also be obtained under bulk-billing.[24]

AMWAC concluded that there were too many GPs in metropolitan areas way back in 2005. Since that time, as documented, the ratio of FWE GPs to population in metropolitan areas has increased significantly. There is little doubt that AMWAC's conclusion applies with even more weight today. Since the ratio of FWE GPs to population in regional areas is almost the same as for metropolitan areas (as is the bulk-billing rate), the same conclusion applies to regional areas.

Implications for the taxpayer

The GP oversupply is already expensive for the Australian taxpayer. Currently the standard fee for a GP service under Medicare is $35.60. There are extra loadings for services to children aged under 16, and in non-metropolitan areas for patients with Health Cards (who could constitute up to 50 per cent of the patients a GP sees). This latter loading is $9.10. It is available for services billed by limited registration IMGs as well as to fully registered GPs.

A GP working full-time will normally see at least 150 patients a week. Over a 48-week year this amounts to at least 7,200 items. At around $40 a service, this would deliver a gross income of $288,000 a year. GPs in corporate clinics are expected to see more than 150 patients a week.

According to the Productivity Commission report, the Australian Government's expenditure on GPs (which includes practice incentives programs) was $6.7 billion in 2011-12. [25] There were 21,119 FWE GPs billing on Medicare in 2011-12 (see Table 4). This means that the average expenditure per FWE GP in 2011-12 was $317,000.

Conclusion

The $317,000 per FWE GP is a gross amount from which office and other expenses must be deducted. However, with most services bulk-billed, GPs do not have to worry about bad debts or about the costs of collecting their fees. They are paid directly by the Government.

With gross returns at this level it is no wonder so many IMGs are keen to come to Australia and enter the GP workforce (permanently if possible). Employers of IMGs who hold limited registration also have a strong pecuniary motive to employ these doctors because the IMG will rarely receive more than half of the $300,000 plus gross that their activity generates.

The existing excess of GP numbers in metropolitan areas is likely to expand rapidly as the numbers of GP registrars finishing their training doubles to about 1000 a year over the next few years. Most of these registrars are Australian- trained and therefore when they gain full registration as specialist GPs can practice wherever they choose in Australia. The IMGs among those completing their specialist GP training will have to serve in districts of workforce shortage for a period. Some of the locally trained will have constraints on where they can practice due their acceptance of bonding arrangements. But there is no doubt that GP numbers in over-serviced metropolitan areas are set to expand rapidly because of the surge in new GP numbers.

In addition there will be an increasing flow of IMGs into metropolitan areas as those currently practising in non-metropolitan areas gain full registration and complete the period they must serve in districts of workforce shortage. They are likely to move to metropolitan areas when this happens. When they move, their employers will have a continuing interest in replacing them with more IMGs on limited registration – because they cost less to employ than fully registered GPs.

The Federal and State Governments are preoccupied with getting more GPs into regional areas. They are paying no attention to the prospective costs of GP oversupply in metropolitan areas (and some regional areas). As noted, fully registered GPs can practise where they please no matter how many doctors are already practising in the vicinity. The potential to squeeze more GP services out of an existing population is high because there is no financial constraint on prospective patients in a bulk-billing situation and it is up to the GP to decide whether extra services are appropriate for the patient. As AMWC has argued, when GPs have to chase patients the result is not good medicine. It is excessive service.

This circle needs to broken. The recruitment of further IMGs from overseas on limited registration to GP and hospital doctor positions should cease. It is time to revisit the Government's policies which define 'areas of need' or 'districts of workforce shortage'. 'Districts of workforce shortage' are defined as those where 'the provision of medical services currently falls below the national average'. This definition makes no sense given that there is now very little difference between the ratio of population to FWE GPs and bulk-billing rates in metropolitan and rural districts.

If the Australian Government ceased to allow further sponsoring of GPs on 457 visas and further issuance of visas to GPs under the permanent-entry skilled visa program, it would not have the dire consequences projected by *Health Workforce 2025*. The IMGs already here are not all going to pack up and leave. Rather, most will seek to stay on in the hope of eventually obtaining full registration. As we have seen, they will be joining thousands of other IMGs already in Australia who are not employed as doctors. If there is need to augment the supply of locally trained graduates, the GP workforce should be supplemented from this source. Many are permanent residents and on this account should be the first priority in filling such gaps. The savings from controls over GP servicing recommended below could be used in part to provide pathways for these IMGs to be properly trained as specialist General Practitioners.

The focus of GP policy should be on managing the sharp increase expected in the number of locally trained medical graduates.

The current policy of directing IMGs on limited registration into regional areas should be abandoned. Surveys of morbidity indicate that regional communities require more medical service per person than do metropolitan communities. The demands on GPs skills are also greater in these communities because GPs are often required to provide procedural services in local hospitals as well as GP clinical services. Regional GPs also do not have the same access to specialist back-up as do GPs in metropolitan areas. Yet the Federal and State Governments have directed limited registration IMGs, most of whom have not undergone a thorough assessment of their clinical skills, into the front line to do this work. It would be far better if the highly trained and accredited local GP registrars served in shortage areas when they complete their training.

GPs should serve where they are needed. There are a variety of ways this can be done, as through granting places in medical school and within the GP training program in return for accepting service obligations in areas of need when their training is completed. But more needs to be done.

GPs are essentially public servants. Nevertheless, the past history on this issue indicates that they cannot be conscripted to work as directed by the Government. However the Government can limit the places where GPs are permitted to practise through its controls over the issuance of Medicare provider numbers. This already happens with GPs who are IMGs. The Government will only issue provider numbers to these IMGs if they serve in districts of workforce shortage (until they have completed their required period of service in such districts). In the case of fully registered GPs, all that would be required to limit over-servicing in metropolitan or any other locations would be to not issue any further provider numbers in such areas until the oversupply situation ends.

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