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Australia's New Health Crisis – Too Many Doctors

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Executive Summary

The dominant view within the Commonwealth and State Government medical workforce decision-making bureaucracies is that Australia has a serious shortage of General Practitioners (GPs) and hospital doctors, that is those who work as non-specialist Hospital Medical Officers (HMOs).

This diagnosis has dominated policy on the matter since the early 2000s. In response, the Commonwealth and State Governments have encouraged the recruitment of international medical graduates (IMGs) and allowed them to practise on concessional terms, as long as they do so in districts of workforce shortage. These are defined by the Commonwealth as districts where the ratio of population to doctors is above the national average.

GPs have been permitted to migrate under Australia's permanent entry skilled migration visa categories as long as they can obtain general registration with the Medical Board of Australia (MBA). This means that they have to possess credentials equivalent to those of domestic medical graduates who have completed their intern year.

In addition, employers of GPs or HMOs can sponsor as many IMGs as they like on temporary entry 457 visas. Under concessions stipulated by the Commonwealth and State Governments, the MBA is required to register these IMGs on a limited basis if they have completed a medical degree and internship – whether in a western medical school or not. The MBA cannot normally demand an independent assessment of their clinical skills (that is, an assessment of their capacity to diagnose and treat the conditions likely to be presented by Australian patients). Limited registration currently means that the IMGs in question are permitted to practise for up to four years under supervision, on the condition that they make some progress towards updating their qualifications to meet Australian GP-assessment standards.

By contrast, Australian-trained medical graduates can only practise as GPs after they have successfully completed a three to four year GP Registrar program, which involves far tighter supervision than is the case for IMGs on limited registration. Accredited GP trainers under the registrar program cannot supervise more than two registrars at one time. Supervisors of IMGs do not have to be accredited trainers and can supervisor up to four IMGs at the same time.

These concessions have been remarkably successful in increasing the non-metropolitan GP and HMO workforce. According to current MBA registration statistics, there were 2,731 IMGs working on limited registration as GPs and 3,430 as HMOs.

Such has been this success that the ratio of population to GP in non-metropolitan areas is now well below the benchmark of 1,500 people per fulltime-workload-equivalent (FWE) GP ratio considered to provide an adequate level of service. The only areas where this does not apply are in some remote locations, including in Northern and Western Queensland, the Northern Territory and north-

western Western Australia. Another indication is that the proportion of GP services which are bulk billed reached 79.1 per cent in 2010-11, up from 67.6 per cent in 2003-04.

Despite this achievement, there has been no change to the concessions facilitating recruitment of IMGs. Employers can still sponsor as many IMGs on 457 visas as they like and GPs are still eligible to migrate under the permanent entry skill programs. Yet there are clear signs that the policy has overshot its goal.

Australia is awash with doctors wishing to become GPs.

There are now thousands of IMGs in Australia on temporary visas who are anxious to join the permanent entry medical workforce and thousands more who are permanent residents who were trained in non-western medical schools but who have not yet succeeded in updating their credentials to the Australian standard required for general registration.

These IMGs are competing for positions at a time when there is a rapidly expanding number of domestic medical graduates. The latter increased from 1,287 in 2004 to 1,915 in 2009. They are now entering HMO positions and around half are seeking to become GP registrars. One consequence is that there is a large surplus of IMGs seeking the limited number of HMO vacancies now open to them. Another consequence is increased competition for available places in the GP registrar program. Despite an increase in the number of these places from 600 for the 2004 training year to 900 for the 2011 training year, significant numbers of domestic graduates and hundreds of IMGs are missing out on a place.

A case study of GP practice in regional Victoria prepared for this report shows that such is the availability of IMGs for work in 'districts of workforce shortage' that this has facilitated the opening of many new GP clinics based on IMG employment. One employer alone, Tristar, has opened 29 such clinics over the past few years. Despite the alleged GP shortage, the employer has had no difficulty attracting IMGs to work in these clinics. This development has generated serious concerns within the regional GP workforce about whether the level of supervision required by the MBA for the IMGs in question is adequate.

What is to be done?

The first place to start should be the removal of the double standard on the assessment of domestic medical graduates and IMGs who wish to become GPs. It has been sustained because of the politically driven judgement that compromises on assessment standards were justified by the seriousness of the doctor shortage. This rationale no longer exists. IMGs should not be allowed to practise on limited registration until they have satisfactorily completed an independent assessment of their clinical skills.

This change will not be easy to accomplish. There is a widespread belief within the Australian public, and within the medical workforce itself, that the arbiter of decisions on assessment standards is the MBA. But this is not the case. This is the province of the Australian Health Workforce Ministerial Council, which includes each of the State and Territory Ministers of Health. Any move to require a compulsory assessment of clinical standards will require a collective decision of the Ministerial Council, following which each State and Territory will have to pass enabling legislation. Needless to say, this is likely to be a protracted process.

The MBA does have more freedom to recommend changes to the supervision rules required for IMGs with limited registration. These rules have to be approved by the Ministerial Council but do not need accompanying State and Territory legislation. There is a strong case for tightening these rules so they parallel the much closer supervision imposed on GP registrars.

Given the enormous stock of IMGs already in Australia, it is urgent that this stock not be augmented any further through additional migration. This will require changes to the rules governing the issuance of permanent or temporary entry to IMGs. There were 1,010 visas issued to medical practitioners under the points-tested permanent visa categories in 2009-10 and 460 in 2010-11. IMGs can only be visaed under these visa categories if their occupation is on the Skilled Occupation List (SOL). This is compiled by Skills Australia (SA) and currently includes GPs. SA based its assessment on the record of employment of domestic medical graduates. SA did not consider the situation of IMGs. This is where the oversupply lies.

For IMGs entering on 457 visas, DIAC will not issue a visa until the MBA has approved the applicant for limited registration. In turn, the MBA will not grant this registration unless the position has been classified by the Department of Health and Ageing as a 'district of workforce shortage' and the relevant State or Territory Health Department has affirmed that the location meets its 'area of need' criteria.

This is the component of the medical workforce decision-making structure most amenable to a rapid response to the oversupply situation. The rules on which areas are classified as 'districts of workforce shortage' and 'areas of need' are opaque. Since the Commonwealth pays the bill for services billed on the Medicare system, it can unilaterally reduce the locations in which IMGs can bill on this system and thus the number of locations from which employers can sponsor IMGs on 457 visas. This will lead to a reduction in the number of 457s visas being issued for GPs and HMOs (totalling 2,420 in 2010-11).

Finally, there is an urgent need for a new review of the GP workforce situation. This should be tasked, among other things, to assess what is an appropriate benchmark of population to GP ratio in today's circumstances, and to establish the extent to which Australia's medical workforce districts meet this standard. The new benchmark should be determined by what is an appropriate level of service rather by an aspiration to achieve the same ratio of population to doctors as exists in the metropolitan areas.

Australia's New Health Crisis — Too Many Doctors

Introduction

It is taken as axiomatic within Australia's health bureaucracy that there is a shortage of doctors. The Department of Health and Ageing states in its 2009-10 Annual Report that:

> *There is currently a shortage of GPs in Australia… Programs supporting the recruitment and retention of overseas and Australian-trained doctors are important for all communities, particularly those in regional, rural and remote areas of Australia where access to doctors is low to very poor.*[1]

Public discussion of the medical workforce issue reflects this judgement. For example, according to the president of the AMA, Steve Hambleton, Australia has a 'dearth of doctors. Cuts to university places 20 years ago to control a blowout in Medicare payments has resulted in a reliance on foreign-trained doctors'. [2]

This judgement is dubious. The multitude of measures which successive Commonwealth governments have put in place to increase the number of domestic medical graduates, to encourage the recruitment of IMGs and to focus their employment in areas of need is bearing fruit. So much so that this review of the GP workforce indicates that there are a number of signs of oversupply, particularly of IMGs.

Section 1: Background – the changing official stance on the medical workforce

1.1 The era of 'too many doctors'

Concern about doctor numbers has ebbed and flowed in Australia over the past couple of decades. There was a major turning point in the early 1990s when the then Labor Government concluded that there were too many doctors in Australia. The government decided to put a clamp on the number of university places in medicine available for domestic students and to restrict the entry of overseas-trained doctors to the Australian medical workforce. These overseas-trained doctors will be subsequently referred to as International Medical Graduates (IMGs).

The policy to restrict doctor numbers was strengthened when the Coalition came to power in 1996. The Coalition Government sought to dissuade IMGs from entering the Australian medical workforce by passing legislation that prevented new arrivals from billing on the Medicare system until ten years had elapsed from the time they were first registered to practice in Australia. The Coalition Government was aware that, despite the alleged overall surplus of doctors, there was an over-representation in metropolitan locations relative to regional areas and also that there were shortages of medical officers in both metropolitan and regional hospitals. For this reason it allowed IMGs willing to serve as general practitioners in districts of workforce shortage an exemption from the ten year rule. The Commonwealth defined the eligible districts. However, these were not necessarily the same as the concurrent state government designations as to whether a particular location was an 'area of need' – that is where the state believed there was a shortage of doctors. This matters because the states can, if they wish, prevent an IMG from being registered in a district

of workforce shortage if it does not meet their definition of area of need. This issue is explored in sub-section 1.6 below.

Once this hurdle was negotiated the respective State Medical Board would register the IMG on a temporary/conditional basis. That is, the IMG would be restricted to work in the GP practice or hospital of the sponsoring employer on terms set by the relevant Medical Board.

IMGs were also permitted to serve as Hospital Medical Officers (HMOs) in the hospital system whether in metropolitan or regional areas. The strategy was to make the employment of IMGs conditional on their service in positions which were hard to fill with resident doctors.

One other decision crucial to this story concerns the rules governing registration for General Practice on the part of doctors trained in Australia. Domestic graduates obtain general registration after completing their medical degree and a one year intern program. The equivalent requirement for IMGs is that they must pass the English language, medical knowledge and clinical tests set by the Australian Medical Council. However, since 1996, newly graduating Australian-trained doctors wishing to work as GPs have had to complete a GP postgraduate training program involving a three or four year period of further education and supervised practice. This leads to the granting of Fellowship status with the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). Once the Fellowship had been attained the domestic graduate is free to practise anywhere in Australia.

The rules for IMGs are quite different. IMGs can practise on a temporary/conditional basis without obtaining GP Fellowship status or without completing the AMC examinations, though their place of work has been governed by the ten year rule. The story on these concessions is complex and is recounted in Section 2.

The government's motivation for this reform for domestic graduates was partly to bring about the desired reduction in the rate of growth in the number of doctors able to bill patients. For this reason, it initially allocated a small annual quota of places into the GP registrar program of just 400. The government also wanted to improve the quality of GP preparation before allowing independent practice. Previously, Australian graduates who had completed their intern training were permitted to practise as GPs without any requirement of postgraduate general practice training or any period of supervision by an experienced GP.

The arrangements described above remain in place to this day, though the number of GP registrar places has been greatly expanded. One change has occurred. Since 2010, New Zealand citizens or permanent residents who completed medical training in New Zealand are no longer affected by the ten year rule. Curiously, this concession does not apply to overseas students trained in medicine in Australia.

1.2 The Government changes its mind: from too many to too few doctors

Since 2003, the Government's policy on the medical workforce has reversed. Its stance since this time has been that there are too few doctors. This judgement reflected a slide in the proportion of medical services being bulk billed in both regional and metropolitan areas. It gathered further political heat with increasingly desperate appeals from regional and sometimes from outer suburban

communities for the government to do something about their inability to recruit doctors for their communities.

1.3 Measures to increase domestic training

There was also a policy somersault on the domestic opportunities for medical training. Five new medical schools were announced for opening by 2005, with more to follow. As a consequence, the number of domestic completions from Australian medical schools increased from 1,287 in 2004 to 1,915 in 2009. Further increases are in the pipeline: domestic undergraduate commencements in courses leading to provisional registration as a medical practitioner increased from 1,699 in 2004 to 2,955 in 2009.[3] The numbers of overseas students completing medical degrees in Australia have also expanded, from 203 in 2003 to 465 in 2009. Most of these subsequently seek to establish themselves within the Australian medical workforce.[4]

There is a parallel expansion in the number of these domestic graduates entering General Practice. The number of training places available in the GP Registrar program has increased from 600 for the 2004 training year, to 700 for the 2010 training year, 900 for the 2011 training year, 1,000 for current applicants seeking a place for the 2012 training year and 1200 places are anticipated by 2014.[5] These places are being filled. Indeed there is currently a surplus of applicants because the registrar program is also receiving hundreds of applicants each year from IMGs in Australia on permanent residence visas.

The number of domestic applicants for these places increased from 761 for the 2007 training year to 1289 for the 2012 training year. As will be evident, this is well above the 1,000 places available for this year. Many are missing out, an outcome explored in more detail later (Section 5.1). These circumstances have facilitated a significant increase in the number of permanent resident IMGs being recruited into the registrar program. For the 2011 training year, 331 IMGs accepted places in this program.

1.4 Promoting the recruitment of IMGs

Given the perceived urgency of the undersupply situation by 2003, the Coalition Government's priority was an immediate expansion of the medical workforce. To this end, in 2003, the Government introduced its Strengthening Medicare package. This provided financial assistance for the recruitment of IMGs, particularly those holding temporary visas. The advantage of tapping into this group from the government's perspective is that they were required, as a condition of their visa, to work in the particular job they were sponsored to. Most were sponsored to hospital work, either as trainees in specialist programs or as junior HMOs. In addition, a substantial minority were sponsored to work in GP practices.

The numbers of these doctors holding temporary visas increased sharply, with several thousand temporary visas being issued to this group in 2002-03 and in every year thereafter. Most left Australia after completing their appointment, but an increasing share has sought to stay on in Australia in recent years.

The permanent residence door was also opened. After 2001, doctors were permitted to apply under Australia's permanent entry General Skilled Migration program (which includes both the points-tested and State-sponsored visa subclasses). Thousands have since done so, though to be accepted

under the General Skilled Migration program, doctors had to have the credentials necessary to gain general registration with one or other of the State Medical Boards or since 1 July 2010 by the MBA. For this purpose they needed to pass the AMC tests of medical knowledge and clinical practice or to possess overseas qualifications regarded as equivalent. In addition, employers have been free to sponsor as many doctors as they wish under the permanent-entry employer-sponsorship visa subclasses. Those sponsored also have to have gained general registration before DIAC will grant a visa.

There are also a number of 'back-door' entry points — that is ways by which doctors can enter Australia which do not require any assessment of medical qualifications. One such route is via New Zealand. Anyone who can obtain citizenship in New Zealand, no matter what their occupation, can move to Australia without obtaining a permanent or temporary visa. Some 297 New Zealand citizens who indicated that they were doctors arrived in Australia in 2008-09 with the intention of staying permanently or long term.[6] Just over a third of these were not born in New Zealand. Another important back-door entry point for doctors is as a spouse of a principal applicant who has succeeded in gaining a permanent entry visa through any one of the permanent entry programs or by being sponsored by an Australian resident under the family reunion program. Hundreds of doctors are entering as settlers via this route each year.

The point about these 'back door' entry pathways is that there is no screening of the IMGs credentials. Though they must be registered by the MBA before they can work as doctors, they nevertheless add significantly to the ranks of IMGs anxious to join the Australian medical workforce.

1.5 Incentives for IMG employment since 2003

The Commonwealth Government has not rested on its laurels since Strengthening Medicare. Additional initiatives aimed at encouraging IMGs to serve in areas of workforce shortage have been put in place.

One initiative is the Rural Other Medical Practitioners' Program (ROMPS) program, which allows IMGs who are not vocationally recognised (which is the case for all IMGs who are practising under limited registration) to be paid at vocational rates. ROMPS began in 2001. It allowed non-vocationally registered GPs who served in rural and remote areas to claim the full Medicare rebate for GP services (rather the much lower non-vocationally registered rebate). On 1 July 2004 the range of eligible locations was extended to 'areas of consideration', defined loosely as those with population- to-doctor ratios akin to those in rural and remote areas. There was a further extension in 2 April 2007. Areas defined as inner regional (which includes the larger regional centres) were included if they had 'significant workforce shortages'.[7]

The rules governing the ROMPS program are expressed in discretionary language. This means that the decision as to whether an area is an 'area of consideration' can change. The bottom line, however, is that most regional areas are likely to meet the post-April 2007 criteria (though there is no certainty about this since the government has not released any detail indicating the areas eligible). Thus, since April 2007, IMGs employed on provisional or limited registration are likely to receive the vocational rebate, even though not vocationally registered.

A second initiative allows IMGs on temporary visas to apply for permanent residence if they work in districts of workforce shortage for five years and can obtain the RACGP Fellowship.[8]

A third initiative concerns 'scaling' provisions. Since 1 July 2010, IMGs subject to the ten year rule can have their obligatory period of service in districts of workforce shortage reduced. This concession means that an IMG can claim a reduction in the ten year requirement. The reduction is five years for those serving in Very Remote areas. After five years service they can practise anywhere in Australia if they have obtained RACGP or ACRRM Fellowship status. The reduction is four years if the service in Remote areas, three years for service in Outer Regional areas, and one year for service in Inner Regional areas.[9]

1.6 A note on 'districts of workforce shortage' and 'areas of need'

The measures described above have contributed to a large increase in both the numbers of IMGs resident in Australia and employed in the medical workforce since 2003. As indicated in Table 1, the number of IMGs billing on Medicare in Australia increased from 6,444 in 2003-04 to 9,191 in 2009-10. This increase of 2,747 constituted 75 per cent of the total increase of 3,644 in the number of GPs billing on Medicare in Australia over this period.

Table 1: General Practice Workforce, headcount by where basic qualification was obtained, Australia, 2000-01 to 2009-10

Place of basic qualification	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	Growth 2003-04 to 2009-10 No.	Growth 2003-04 to 2009-10 % of total
Total	23,085	23,050	23,051	22,949	23,378	23,834	24,272	24,903	25,726	26,613	3,664	100
Overseas	6,013	6,109	6,320	6,444	6,807	7,222	7,564	8,082	8,651	9,191	2,747	75
Australia	17,072	16,941	16,731	16,505	16,571	16,612	16,708	16,821	17,075	17,422	917	25

Notes: GP headcount is a count of all GPs who have provided at least one Medicare Service during the reference period and who have had at least one claim for Medicare Service processed during the same reference period. Note that the headcount figure includes several thousand medical practitioners who provide only small numbers of services through Medicare each year. Given the high proportion of casual and part-time practitioners accessing Medicare, 'head count' of GPs generally overstates the workforce supply in Australia.
Source: Department of Health and Ageing, General Practice Workforce Statistics, October 2010

The work location of these IMGs has been shaped by the definition of 'areas of workforce shortage'. As noted, IMGs can only bill on the Medicare system if eligible for exemptions under the ten year rule. For this to apply, the location has to be a 'district of workforce shortage' (DWS). The Commonwealth government decides which districts qualify. They are defined as follows:

> *'A DWS is a geographical area of Australia in which the population's need for healthcare has not been met. Population needs for health care are deemed to be unmet if a district has less access to medical services than the national average.'*[10]

This is an extraordinarily wide definition. It includes almost all of regional Australia since almost all locations in regional Australia have a population-to-GP ratio higher than the national average. This point is documented in Table 5 below. In reality, the Commonwealth's designation of a DWS is far more nuanced than is implied by the above quotation. The latest map of DWS areas on the Doctor Connect website, excludes some areas of regional Australia, including most major regional cities.

In the case of Victoria, however, most of the large towns along or in the vicinity of the Murray River are classified as DWS areas, including Wodonga, Wangaratta, Echuca, and Swan Hill. Mildura,

Bendigo and Ballarat are excluded. For NSW, most regional areas of the state are included. For Queensland, most coastal areas are not classified as DWS areas, including the Gold Coast and the Sunshine Coast.

From the point of view of the prospective IMG however, this is not the end of the story. The Commonwealth government statements on the DWS rules indicate that IMGs considering applying for jobs also need to take into account state government 'area of need' definitions. The government's factsheet on the matter informs readers that an 'Area of Need' (AON) is any area which the state and territory governments think lacks doctors. If a state health department decides the proposed location is not an AON, the Commonwealth will not provide a ten year exemption and the MBA is not permitted to register the doctor in question. The states vary in the strictness with which they make judgements about AON locations.

Victoria is at the soft end of the spectrum. Up to 2003, the Victorian Department of Health made its own judgement about whether the sponsored job was in an AON. This practice ceased after 2003. The Victorian government decided that it would not second guess the Commonwealth's judgements on districts of workforce shortage.

This is not the case in NSW or Queensland. The NSW Department of Health reaffirmed in December 2010 that limited registration cannot occur unless the IMG has a job in an 'area of need' location. The NSW rules state that these locations must fit within the Commonwealth's 'district of workforce shortage' designations. However, NSW Health requires the sponsoring employer to provide evidence of labour-market testing, such as copies of local advertisements. It also asks for evidence that service delivery will be impacted if the position is not filled by an IMG. To this end, the guidelines state that the employer must provide 'information on how the vacancy will impact upon the delivery of medical services to the community or information on the factors which the applicant believes are preventing the successful recruitment of an Australian citizen/permanent resident medical practitioner with specialist registration.' (Specialist in this context includes fully registered permanent resident GPs).[11] If these requirements are not met, the applicant cannot gain an exemption from the ten year rule, nor will the MBA register the IMG.[12] The rules in Queensland are similar.

This is a complex and confusing set of arrangements. There does seem to be some narrowing of the range of DWS and AON locations. Nonetheless, the latest DIAC visa-issued data shows that prospective employers, despite the web of bureaucracy they face in gaining access to IMGs via temporary residence (457 visas), are still recruiting them in large numbers. In 2010-11, DIAC issued 457 visas to 1,190 principal applicants who were General Medical Practitioners and another 1,230 who were Resident (Hospital) Medical Officers. This number includes an unknown number of renewals. However, to judge from the number coming from overseas and from the number taking the AMC medical knowledge test for the first time (see Section 2.2), most are new appointments.

All had to jump the hurdles described above. When both groups are combined, 610 were for jobs in Victoria, 540 in NSW, 500 in Queensland, but only 280 in WA, which has a relatively high population to doctor ratio.[13]

Section 2: The institutionalisation of the assessment double standard; high for domestic graduates, low for IMGs

This augmentation of the Australian medical workforce from IMG sources has been achieved at the price of a decline in the assessment standards for IMGs. This has occurred at the same time as the requirements for training and assessment of domestic graduates who wish to become GPs have been strengthened.

On the face of it, IMGs must meet rigorous standards. In 1992, all IMGs who were permanent residents, including those from the United Kingdom who had previous been exempt, were required to complete the Australian Medical Council (AMC) accreditation examinations before they could obtain general registration to practise in Australia. The assessment involved passing a test of medical knowledge and a clinical examination in which candidates had to demonstrate skills equivalent to final year medical standards for Australian graduates.

However, until recently, all the State Medical Boards (reflecting their respective State Health Department directives) continued to register IMGs on a temporary/provisional basis through the 1990s and 2000s without requiring that they first complete the AMC examinations. There have been two phases to this story and they need to be told separately. The first concerns the arrangements in place until 2007. The second concerns the arrangements introduced following the Council of Australian Government (COAG) decisions in 2007 regarding the assessment and registration of IMGs.

2.1 Assessment standards for IMGs to 2007

The exemption of IMGs from the AMC examinations was not regarded as a big issue in the 1990s because most temporary IMGs had been trained in the UK. But over the last decade most have come from non-western countries, where far less is known about the standards of the training and its relevance to practice in Australia. Nevertheless, up to 2007, these IMGs were normally granted temporary/provisional registration by the State Medical Boards on the recommendation of the sponsoring employer. There was rarely any independent assessment of their medical knowledge or clinical skills. That is, there was no independent evaluation of their capacity to diagnose and treat the range of medical conditions typically presented by Australian patients in GP or hospital settings.

Another source of temporary/conditional registered IMGs during this period was the thousands of IMGs living as permanent residents in Australia who entered via one of the routes described above. Some have successfully passed the AMC examinations and then, after working as a HMO, have joined the GP Registrar program. Some have tried and failed to complete the AMC examinations. Nevertheless, all of these IMGs, including those who failed, were able to obtain temporary/conditional registration if proof of identity, training, medical experience and (since 2005) evidence of English language competence was confirmed by the relevant State Medical Board and if recommended by a sponsoring employer. Like their counterparts on temporary visas, they have had to serve in the hospital system as HMOs or as GPs in 'area of need' locations.

This was a very striking outcome. The Coalition Government did achieve an expansion in the medical workforce. But it occurred at the cost of a sharp difference in the assessment standards required of temporary/conditionally registered IMGs relative to the standards required of domestic graduates.

Needless to say, these arrangements were controversial. Various groups of doctors expressed criticism, though for the most part they did so quietly to the state health department bureaucracies and the state medical boards. The Commonwealth and state governments were reluctant to act because their priority was to alleviate the alleged doctor shortage. They feared that to tighten assessment standards for IMGs would jeopardise this priority. This was notwithstanding the sharp contrast between the laxity of Australian assessment rules by comparison with the rules applying in the UK, Canada and the USA at the time.[14] For example, in the UK, IMGs cannot take up a post in the public system unless they first pass the Professional and Linguistic Assessment Board (PLAB) test. This involves a medical knowledge and clinical test which is designed 'to assess your ability to work safely in a first appointment as a senior house officer in a UK hospital in the National Health Service'.[15]

The cover was blown off the Australian arrangements by the disastrous 'Dr Death' saga in Queensland. Dr Patel had been recruited as a hospital medical officer to the Bundaberg base Hospital and temporarily/conditionally registered to practise on the recommendation of the hospital and a medical recruiter. Despite no assessment of his skills (either by the AMC or by the Royal Australasian College of Surgeons), Dr Patel practised as a surgeon from 2003 to 2005 (indeed for most of this period he was Director of Surgery at the hospital). The outcome was a string of botched operations.[16] This incident helped prompt the Council of Australian Governments (COAG) in 2006 to announce that the assessment standards would be tightened.

2.2 Assessment standards for IMGs since 2007

In 2007 COAG announced that new pathways for IMGs would be created into general and specialist practice. For non-specialists, IMGs were to be split into two categories, those who would enter by a 'competent' authority pathway and those by a 'standard' pathway. The former included doctors who had been trained in the UK, Ireland, USA, Canada or New Zealand or had been accredited to have achieved these standards (as by passing the PLAB exams in the UK) after having been trained elsewhere. The latter, or 'standard', pathway covered IMGs from all other countries of training or accreditation.

Those entering under the competent authority pathway did not have to complete the AMC medical knowledge or clinical examinations. The numbers applying are large. For the year 2010 there were 1,355 applicants of whom 1,200 were issued Advanced Standing[17], meaning that they did not have to sit the MCQ or Clinical examinations. Instead, they may be required to undertake a workplace-based assessment while working under supervision.[18]

Those seeking medical appointments under the standard pathway are required to complete the AMC medical knowledge test before being able to gain provisional or limited registration as a HMO or GP. This requirement, implemented since mid-2008, was a breakthrough. The medical knowledge test works as a filter, sifting out candidates who cannot speed read and answer correctly a majority of a bank of multiple choice statements about medical knowledge. Very large numbers of IMGs have since taken the MCQ test, with 3,112 newly presenting in 2008-09 and another 2,610 in 2009-10. IMGs can sit the test whether already in Australia as permanent residents or resident overseas and hoping to gain temporary employment in Australia. The AMC does not separate out the results for those two groups. However the AMC has reported that 2,263 IMGs took the MCQ in 2010 for the first time, of whom 1,295 passed.[19] It is worth noting in passing, that under pre-2007 arrangements,

the 968 who did not succeed would have been eligible for temporary/conditional registration to practise in Australia if they had found an employer willing to sponsor them.

What about the IMG's clinical skills? These are central to successful practice either as a hospital doctor or GP. There was an opportunity to require satisfactory passing of AMC clinical examination. Instead, the Implementation Committee set up by COAG to negotiate the new arrangements, which included all the state health departments, decided to allow those entering on the Standard pathway and the Competent Authority pathway, to avoid the AMC clinical assessment.[20] However, the MBA can require a pre-employment structured clinical interview (PESCI) under certain circumstances. This determination was enshrined in the Commonwealth/State agreement which set up the new Australian Health Practitioners Registration Authority (AHPRA) and the state legislation which followed. The MBA is required to stipulate its rules for limited registration in a manner consistent with the Commonwealth/State agreement. This outcome was a compromise shaped by State and Commonwealth health departments concerns about doctor shortages.

The MBA can only require an IMG entering under the standard pathway to undertake a PESCI if the location of the practice is in a high risk area. The MBA states in its submission to the Commonwealth inquiry into Registration Processes and Support for Overseas Trained Doctors, that if an IMG proposes to practise in a rural or remote location 'the Board will require a satisfactory result at a pre-employment structured clinical interview (PESCI)'. [21]

The MBA has not provided any information as to how often it is requiring the PESCI. It is seems likely that this is not required for the majority of IMGs who are practising in regional towns. The records of the authorities accredited to administer the PESCI indicate that the numbers required to take it are small relative to the number passing the MCQ. In Victoria, the accredited authority is the Rural Workforce Agency of Victoria (RWAV), a semi-government body whose income comes from recruiting and placing IMGs in medical positions. RWAV conducted 179 PESCIs in 2010. In Queensland, the accredited agency is the ACRRM. ACRRM conducted 221 PESCI's in 2010. Only a handful was conducted in NSW.[22]

The PESCI involves a panel of doctors who assess the applicant across six domains of Rural Medical Practice. In the case of rural GP positions, these are Communication Skills, Ethics, Applied Professional Knowledge and Skills for Rural Practice, Organisational and Legal Issues and Understanding of Rural General Practice. No live patients are involved. The interview sometimes lasts for less than two hours. Given the range of topics covered, there is little opportunity to assess the candidates' clinical skills. As a result, even for the minority of IMGs who are required to take it, the PESCI is not comparable in rigour with the AMC's clinical examination which focuses on clinical skills and involves live patients.

The situation differs for IMGs wishing to become specialists. AHPRA, at the request of the MBA, has appointed specialist colleges to assess the comparability of specialist IMGs to Australian-trained specialists. For example, the Royal Australasian College of Surgeons would examine an IMG who has international specialist qualifications in surgery. By contrast, neither RACGP, nor ACRRM, the colleges responsible for accrediting GP registrars, have any role in decisions about whether an IMG can practise safely under limited registration.

2.3 Supervision requirements for IMGs

Supervision is critical given the deficiencies of the clinical skills assessment (if it is required at all) for IMGs granted limited registration to practise as GPs. At first, the state medical boards set the rules on supervision with NSW being tough relative to Victoria.[23]

In June 2011, the MBA issued national guidelines on the matter. It will henceforth not permit an individual doctor to supervise more than four IMGs under limited registration.[24] Under the new rules the supervising doctor must report in detail about the IMGs performance across all aspects of clinical practice. A report is required after three months then annually. The level of supervision can vary from shared responsibility for patients to full IMG responsibility, depending on the Board's judgement about the level of supervision required.

Despite this tightening of the supervision rules, they still fall well short of what is required of GP registrars. The IMG employer makes the choice of supervisor, who is likely to be part of the employer's practice. There is no arms-length assessment or any provision for independent inspection by the MBA, a situation which the Chair of the MBA, Dr Joanna Flynn admits is not satisfactory.[25] By contrast, all practices selected as part of the GP registrar program have to be accredited by the RACGP or ACRRM, as do the supervising doctors. They are not permitted to supervise more than two doctors at any one time. In addition, the supervising trainer must meet a range of obligations, including the amount of time spent with the GP registrar. Standard T. 9 stipulates that 'the trainer must be available for teaching, support and discussion for 3 hours per week for the registrar's first 6 months of general practice training and 2 hours per week for the second six months.[26]

Section 3: The size and distribution of the IMG workforce

3.1 Growth in the number and birthplace of IMGs in Australia

If an IMG wishes to enter the medical workforce since mid-2008, it has to be done through either the competent authority pathway or the standard pathway. The former has proved to be popular. As noted, in 2010, 1200 IMGs were granted Advanced Standing under the competent authority pathway. Some would have entered Australia on 457 visas and therefore would have had to have obtained an employment offer first. Hundreds of others appear to be coming as permanent residents, mostly under the General Skilled Migration program. The latter do not need a job offer in order to obtain their visa, but do have to be accredited by the MBA as holding specialist credentials (including in General Practice) in the field they wish to practise in.

There are no published statistics on the numbers seeking entry to the Australian medical workforce each year via the standard pathway. In 2010 some 1,999 IMGs passed the AMC MCQ (some after multiple attempts). All those passing would be eligible to apply for GP or HMO positions on limited registration. A significant proportion must have done so given the number of 457 visas issued to IMGs as GPs or Resident (Hospital) Medical Officers in 2010-11 (1,190 to GPs and 1,230 to Resident Medical Officers). At least half of these must have entered under the standard pathway. Fears that requiring IMGs to pass the medical knowledge test under the standard pathway would stifle the flow to Australia have proved to be groundless.

Most of the IMGs receiving 457 visas were born in non-Western source countries. This is shown in Table 2, which provides the latest data held by the Centre for Population and Urban Research on the birthplace of 457 visa holders. It is for the year 2008-09.[27]

Table 2: Overseas arrivals and departures of Medical Practitioners on 457 visa by country of birth, permanent and long-term movements, 2008-09

Country of birth	Arrivals	Departures	Net
United Kingdom	591	147	444
South Africa	201	37	164
Ireland	97	16	81
Canada	50	13	37
United States of America	40	10	30
Main English-speaking country total	979	223	756
India	762	397	365
Malaysia	296	76	220
Sri Lanka	196	115	81
Pakistan	128	46	82
Philippines	122	58	64
Germany	108	45	63
Iran	82	51	31
Burma Myanmar	49	27	22
Singapore	45	11	34
Other country of birth	494	241	253
Non-English-speaking country total	2,282	1,067	1,215
Total	3,261	1,290	1,971
Per cent Main English-speaking country	30.0	17.3	38.4

Source: Department of Immigration and Citizenship, Overseas Arrivals and Departures data, 2008-09

These data are central to the story told below about the plight of many IMGs. A decade ago most 457 holders who were doctors came from the UK. They typically came for short periods of work mixed with sun and surf after completing their intern year in the UK. The great majority then returned to the UK. As Table 2 shows only a minority of 457 visa holders who arrived in Australia in 2008-09 were born in the UK or in the broader category of Main-English-speaking-countries. The majority were born in Non-English-Speaking-Countries, where most would have been trained. These IMGs are attracted to Australia because of the vastly better conditions of work and remuneration. Most aspire to join the Australian medical workforce on a long term basis and to obtain permanent residence visas as soon as possible.

Nevertheless, those on temporary visas who cannot gain a renewal from an employer will have to leave. The current policy of the MBA is to require IMGs working as GPs to obtain their fellowship with the RACGP or ACRRM within four years of beginning their limited registration (or to prove that they have made considerable progress towards this end). From the point of view of the individual IMG, the situation is fraught with tension. Most have made a major career investment, usually

involving movement of their family to Australia. It is therefore crucial that they achieve the required assessment standard.

3.2: How many IMGs are working as GPs or Hospital Medical Officers?

It is not possible to put a precise figure on the net contribution of newly arrived IMGs minus those leaving Australia to the employed workforce of GPs and Hospital Medical Officers. Most of the latter aspire to enter the GP ranks eventually. It is clear, however, that the numbers are large, relative to the number entering the GP workforce after training in Australia. All of those receiving 457 visas as GPs and Resident (Hospital) Medical Officers would have had to be sponsored by an employer and to have gained limited registration from the MBA before DIAC would grant the visa. According to DIAC stock counts, there were 2,110 Resident Medical Officers in Australia on 457 visas as of 30 June 2011 and another 2,200 General Medical Practitioners.[28]

Registration data tell a similar story. According to the MBA, as of 29 January 2011, there were 2,731 IMGs on limited registration in AON positions (mostly as GPs) and 3,430 on limited registration who were employed in the hospital system in postgraduate training or supervised practice.[29] The MBA cannot provide trend data because it only began registering doctors in July 2010.

Another indicator of the growth in reliance on IMGs is the number of doctors who have been granted exemptions from the ten year rule by the Department of Health and Ageing. This refers to doctors who have been allowed to bill on the Medicare system despite not completing ten years medical service in Australia after obtaining initial registration. Their number has increased from 2,290 in 2004 to 6,576 in 2010.[30] This total includes both specialists and general practitioners

For the stock of 2,110 IMGs in Australia on 457 visas as GPs and the 2,200 IMGs as Resident (Hospital) Medical Officers, the key issue is whether they can obtain their Fellowship within the four year deadline. The RACGP has created various pathways, including a practice eligible pathway which allows IMGs to be assessed in part on their workplace performance while working as GPs. However, less than half of those taking the required examinations for the practice eligible route were passing by 2004.[31] This continues to be the case currently according to the RACGP.[32] Those who fail can continue to practise, pending the MBA's judgement about whether they are making adequate progress towards the Fellowship over the four year period normally allowed on limited registration.

This is a powder keg situation. We have a temporary IMG workforce in Australia that mostly wishes to stay permanently and thus will not leave without a struggle. In addition, there are thousands of IMGs in Australia who hold permanent residence status, many of whom are also striving to gain GP work on limited registration and complete their RACGP or ACRRM Fellowship while doing so, or to complete their AMC accreditation examinations.

The Census provides the best source of such data on the number of IMGs in this situation. We have to depend for the time being on the 2006 Census. Table 3 details the number of persons with degree qualifications in Medical Studies who arrived in Australia between 2001 and 2006 and who were still here at the time of the August 2006 Census. This period overlaps with the government's opening up of the migration process to IMGs described earlier. As of August 2006, there were 1,704 such persons living in Australia who were born in Main-English-Speaking-Countries (MESC) and 4,998 who were born in Non-English-Speaking-Countries (NESC), or 6,704 overseas-born in all. The analysis is

limited to those aged 25-64 in order to eliminate those of retirement age. Of the NESC-born persons with degrees in Medical Studies, only 56.8 per cent were employed as Medical Practitioners (GPs and specialists) with the rest (2,159) not so employed. This figure compares with the 84.3 per cent of both their MESC-born and their Australia-born counterparts. Some of the 2,159 medically qualified NESC-born not working as GPs would be women not currently in the labour force due to family duties. Nonetheless, it is clearly no exaggeration to use the term 'thousands' to describe the stock of IMGs who are not working in their chosen profession but who would presumably like to be so employed. This is especially if those in this category who arrived prior to 2001 and were not employed as doctors by 2006 were included.

Table 3: Persons aged 25-64 years whose highest qualification is a bachelor or higher degree in Medical Studies by birthplace and year of arrival, number of persons and percentage working as Medical Practitioners, Australia, 2006

	Overseas-born who arrived 2001-2006		Other overseas-born		Australia-born	Total[2]
Workforce outcome	Main-English-speaking country	Non-English-speaking country	Main-English-speaking country	Non-English-speaking country		
	Persons					
Medical Practitioner[1]	1,436	2,839	5,180	10,810	22,509	43,289
Other[3]	268	2,159	1,110	3,644	4,195	11,585
Total	1,704	4,998	6,290	14,454	26,704	54,874
	Per cent					
Medical Practitioner[1]	84.3	56.8	82.4	74.8	84.3	78.9
Other[3]	15.7	43.2	17.6	25.2	15.7	21.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

[1] Medical Practitioner includes both General and Specialist Medical Practitioners.
[2] Total includes those who did not state their country of birth.
[3] Includes the unemployed and those not in the labour force.
Source: Australian Bureau of Statistics, Customised matrix, Census 2006

As is evident from the many IMG submissions to the 2011 House of Representatives Inquiry into Registration Processes and Support for Overseas Trained Doctors, feelings are running very high, with frequent accusations that the Australian assessment authorities are biased against them. It is a situation of the Australian Government's making. The dilution of assessment standards, as described above, has facilitated the recruitment of thousands of IMGs who are having difficulty meeting the Fellowship standards expected of Australian-trained GP Registrars.

Section 4: Improvements in the ratio between population and number of GPs throughout Australia

4.1 The rise in the number of GPs billing on Medicare

In order to assess the significance of the flow of IMGs, we need a measure which tracks their entry into the medical workforce. Since the focus is on the GP workforce, the analysis is based on Medicare statistics. These provide headcounts of the number of GPs billing on the Medicare system as well as estimates of the full-time work equivalent (FWE) number of GPs by location of the GP and

by whether trained in Australia or overseas. They also provide limited information on the ratio of the resident population to the number of GPs resident in each location.

Table 4 provides an overview of the numbers of GPs billing on Medicare. The low point for the headcount of GPs occurred in 2003-04. In subsequent years the number of GPs expanded, slowly at first then rapidly over the last few years. The total headcount increased by 16 per cent between the years 2003-04 and 2009-10. As shown in Table 1, three-quarters of this increase was attributable to IMGs.

Table 4 also shows that this growth was more rapid in the Inner Regional area, where it was 23 per cent, compared with 13 per cent for the Major Cities. The same pattern is evident for the FWE measure of the number of GPs billing on the Medicare system. By 2009-10, IMGs made up 46.2 per cent of the FWE GPs billing on Medicare in the non-metropolitan areas and 38.7 per cent in metropolitan areas.[33]

Table 4: General Practice Workforce, Australia 2000-01 to 2009-10

											Growth 2003-04 to 2009-10	
	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	No.	%
Headcount												
Major Cities	16,568	16,400	16,239	16,047	16,351	16,665	16,863	17,150	17,717	18,180	2,133	13
Inner Regional	3,970	4,058	4,117	4,190	4,257	4,390	4,545	4,778	4,910	5,135	945	23
Outer Regional	1,918	1,923	2,004	2,021	2,047	2,061	2,090	2,171	2,237	2,359	338	17
Remote	390	429	448	431	454	453	477	494	534	525	94	22
Very Remote	239	240	243	260	269	265	297	310	328	414	154	59
Total	23,085	23,050	23,051	22,949	23,378	23,834	24,272	24,903	25,726	26,613	3,664	16
Full-time Workload Equivalent												
Major Cities	12,379	12,443	12,371	12,322	12,594	12,868	13,181	13,506	13,924	14,248	1,926	16
Inner Regional	2,650	2,777	2,835	2,939	3,040	3,136	3,249	3,397	3,543	3,667	728	25
Outer Regional	1,227	1,275	1,308	1,341	1,370	1,380	1,388	1,431	1,482	1,525	184	14
Remote	177	178	191	200	198	196	201	202	208	208	8	4
Very Remote	60	63	68	70	71	68	71	77	74	81	11	16
Total	16,493	16,736	16,772	16,872	17,273	17,649	18,091	18,613	19,231	19,729	2,857	17

Notes: GP headcount is a count of all GPs who have provided at least one Medicare Service during the reference period and who have had at least one claim for Medicare Service processed during the same reference period. Note that the headcount figure includes several thousand medical practitioners who provide only small numbers of services through Medicare each year. Given the high proportion of casual and part-time practitioners accessing Medicare, 'head count' of GPs generally overstates the workforce supply in Australia.
Full-time Workload Equivalent (FWE) is a standardised measure used to estimate the workforce activity of GPs and adjusts for the partial contribution of casual and part-time doctors. FWE is a measure of service provision taking into account doctors' varying workloads. It is generally considered to provide a good overall indicator of medical workforce supply. FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. It recognises that there is a full range of service provision both above and below the average.
Source: Department of Health and Ageing, General Practice Workforce Statistics, October 2010

4.2 Improvements in the availability of GP services

What do all these numbers mean for the availability of GP services? In the mid-1990s when the Australian government was examining the adequacy of GP numbers in Australia, the RACGP argued that an appropriate ratio of population to each FWE GP was around 1,500. This benchmark was adopted by the medical workforce authority at the time.[34] In 1996 this ratio was around 1,000 in the capital cities and around 1,700 for small rural communities.

Most areas of Australia, including regional and rural areas, are now well below the 1,500 benchmark. This is shown in Table 5. Unfortunately, only three years of comparable data after 2003-04 were available which provide information about the ratio of population-to-FWE-GP. The table aggregates data from each Australian Division of General Practice into two categories, main capital cities and the rest of state for each state. The improvement in the ratio over just three years is notable for all rest of state locations, as well as for the NT and ACT. There is still a gulf between metropolitan and rest of state areas in the provision of FWE GPs but it has narrowed significantly in just three years.

Table 5: Full-time Workforce Equivalent General Practitioners and Population per FWE, by Division of General Practice, Australia by state and capital city, 2003-04 to 2006-07

	Population to each FWE GP[1]		Change 2004-2007[2]		FWE GP indexed to Australian average(1.00)	
	2004 ratio	2007 ratio	Ratio	% Change	2004	2007
NSW Capital City	1,037	987	-50	-4.8	1.15	1.14
NSW Rest	1,379	1,206	-173	-12.5	0.86	0.94
Vic Capital City	1,167	1,125	-43	-3.6	1.02	1.00
Vic Rest	1,389	1,204	-185	-13.3	0.86	0.94
Qld Capital City	1,186	1,123	-64	-5.4	1.00	1.01
Qld Rest	1,204	1,159	-44	-3.7	0.99	0.97
SA Capital City	1,095	1,058	-37	-3.4	1.09	1.07
SA Rest	1,247	1,196	-51	-4.1	0.95	0.94
WA capital City	1,295	1,335	40	3.1	0.92	0.85
WA Rest	1,611	1,462	-150	-9.3	0.74	0.77
Tas Capital City	1,245	1,189	-55	-4.4	0.96	0.95
Tas rest	1,336	1,273	-63	-4.7	0.89	0.89
NT Total	2,036	1,883	-153	-7.5	0.58	0.60
ACT Total	1,628	1,487	-141	-8.7	0.73	0.76
Australia	1,191	1,129	-62	-5.2	1.00	1.00

The capital city classification is based on the Divisions of General Practice assigned to Melbourne on the Primary Health Care Research & Information Service classification for 2006-07.

[1] as at 30 June each year

[2] A negative number indicates fewer patients per FWE GP and represents an improved ratio of patients to GP. A positive number indicates more patients per FWE GP and indicates a declining ratio.

Source: Prepared from data supplied by Primary Health Care Research & Information Service (PHC RIS), Key Division of General Practice characteristics <http://www.phcris.org.au>

For NSW, the gap between the ratio of population-to-FWE-GP for Sydney and rest of state fell from 432 in 2003-04 to just 219 in 2006-07. By this time, the population-to-FWE-GP ratio in the rest of NSW was at the quite reasonable level of 1,206, relative to 987 in Sydney. The pattern was similar elsewhere. However, in Perth, though the gap with the rest of WA fell, the ratio of population-to-FWE-GP in Perth itself actually increased over the three years. This was undoubtedly due to the high rate of population growth in Perth at the time.

Table 6 shows this information for the Divisions of General Practice in Victoria. More detail is provided for Victoria because the focus of the subsequent case study is regional Victorian. The ratio of population-to-FWE-GP for regional Victoria (defined here to include all non-metropolitan areas of Victoria) starts at 1,389 in mid-2004. Just three years later, by mid-2007, it had fallen to 1,204. This represents a 13.3 per cent improvement. By comparison, there was a much smaller improvement for

the metropolitan divisions of 3.6 per cent. It is striking that the improvement in the population to FWE GP ratio occurs across almost all GP Divisions in regional Victoria, including the more remote Mallee Division.

Table 6: Full-time Workforce Equivalent General Practitioners and Population per FWE GP, by Division of General Practice, Victoria, 2003-04 to 2006-07

		Full-time Workforce Equivalent			Population-to FWE-GP ratio			FWE GP indexed to Australian average(1.00)	
Div ID	Division of General Practice	*FWE GPs as at 30/6/04*	FWE GPs as at 30/06/07	Per cent change 2004-2007	2004 Ratio	2007 ratio	Per cent Change 2004-2007*	2004	2007
301	Melbourne	259	279	7.7	707	752	6.4	1.69	1.50
302	North East Valley	202	198	-2.0	1,155	1,190	3.0	1.03	0.95
304	Southcity (Inner SE Melbourne)	217	233	7.4	846	874	3.3	1.41	1.29
305	Westgate	117	169	44.4	1,648	1,258	-23.6	0.72	0.90
306	Western Melbourne	239	251	5.0	1,118	1,114	-0.4	1.06	1.01
307	North West Melbourne	233	256	9.9	1,197	1,176	-1.7	0.99	0.96
308	Northern	221	250	13.1	1,100	1,006	-8.5	1.08	1.12
311	Greater South Eastern	175	168	-4.0	1,062	1,161	9.3	1.12	0.97
312	Monash	130	133	2.3	1,053	1,089	3.4	1.13	1.04
313	Central Bayside	144	130	-9.7	1,216	1,398	14.9	0.98	0.81
314	Knox	155	177	14.2	1,282	1,147	-10.5	0.93	0.98
315	Dandenong (& Casey)	266	322	21.1	1,142	1,009	-11.7	1.04	1.12
316	(Mornington) Peninsula	187	219	17.1	1,471	1,310	-10.9	0.81	0.86
303	Inner Eastern Melbourne **	167	} 424	10.7	1,215	} 1,107	-	0.98	1.02
310	Whitehorse **	216			1,169			1.02	
317	Geelong	169	188	11.2	1,361	1,267	-7.0	0.87	0.89
320	Eastern Ranges	123	133	8.1	1,751	1,689	-3.5	0.68	0.68
	Capital City	3,220	3,530	9.6	1,167	1,125	-3.6	1.02	1.00
318	Central Highlands	123	194	57.7	1,352	927	-31.5	0.88	1.22
319	North East Victorian	83	84	1.2	1,280	1,250	-2.3	0.93	0.90
322	South Gippsland	53	59	11.3	1,256	1,118	-10.9	0.95	1.01
323	Central West Gippsland	89	107	20.2	1,221	1,062	-13.0	0.98	1.06
324	Otway	91	100	9.9	1,339	1,226	-8.4	0.89	0.92
325	Ballarat and District	78	89	14.1	1,541	1,372	-11.0	0.77	0.82
326	Central Victoria	69	70	1.4	1,485	1,540	3.7	0.80	0.73
327	Goulburn	64	79	23.4	1,617	1,294	-20.0	0.74	0.87
328	East Gippsland	54	64	18.5	1,400	1,200	-14.3	0.85	0.94
329	Border	61	70	14.8	1,654	1,539	-7.0	0.72	0.73
330	West Victoria	69	77	11.6	1,168	1,057	-9.6	1.02	1.07
331	Murray Plains	49	54	10.2	1,324	1,182	-10.7	0.90	0.96
332	Mallee	57	64	12.3	1,536	1,386	-9.7	0.78	0.81
	Regional	940	1,111	18.2	1,389	1,204	-13.3	0.86	0.94
	Victoria	4,160	4,641	11.6	1,217	1,144	-6.0	0.98	0.99
	Australia	16,874	18,610		1,191	1,129	-5.2	1.00	1.00
% Vic GP workforce which is regional		29.6	30.9						
% Vic population which is regional^		34.6	33.9						

The capital city classification is based on the Divisions of General Practice assigned to Melbourne on the Primary Health Care Research & Information Service classification for 2006-07.

* A negative number indicates fewer patients per FWE GP and represents an improved ratio of patients to GP. A positive number indicates more patients per FWE GP and indicates a declining ratio.

** The Divisions of Inner Eastern Melbourne and Whitehorse amalgamated to form Division 333 Melbourne East.

^ Population data is Australian Bureau of Statistics Estimated Residential Population for beginning of each year.

Information on the of GPs was self-reported by Divisions of General Practice through the Annual Surveys of Divisions

FWE information was obtained from the HealthWiz database (various editions). Please note that after 2004 the calculation methodology was improved. The FWE and services are now allocated to the Division in which the services are claimed. Previously they had been allocated into a single Division, the Division in which the provider billed Medicare the most.

Source: Primary Health Care Research & Information Service (PHC RIS), Key Division of General Practice characteristics <http://www.phcris.org.au>

The contraction in the difference between regional and metropolitan population to FWE GP ratios across Australia has continued over the period 2006-07 to 2009-10. This is evident from the headcount data shown in Table 4. This shows that the number of FWE GPs billing on Medicare continued to increase in non-metropolitan Australia at a greater rate than in metropolitan Australia after 2006-07. It can be calculated from Table 4 that between 2006-07 and 2009-10 the number of FWE GPs increased by 8.1 per cent for metropolitan Australia and 11.6 per cent for the rest of Australia. These increases exceeded the rate of population growth for the period, meaning that there must have been further improvements in the ratio of population to FWE GPs since 2006-07 and a further reduction in the gap between metropolitan and non-metropolitan areas.

These data do not mean that there are no longer areas of doctor shortage in Australia. There are, particularly in more remote areas of Australia. These are primarily located in WA, and include the Pilbara and Kimberly Divisions of General Practice. The Central Queensland Rural Division of General Practice in Queensland is another exception. Each of these had a population to FWE GP ratio in 2006-07 of over 1,500.

The point is rather that it is no longer appropriate to generalise about a shortage of doctors in Australia. The number of GPs, as measured in FWE, has grown rapidly, at about 520 a year over the past four years to 2009-10 (Table 4). It is certain to grow even more rapidly in the medium term given the recent increase in the number of GP registrars (detailed in Section 1.3).

This rate of augmentation of the GP workforce is sufficient to meet what looks like (at first glance) alarming projections of the need for GPs. A recent academic study which takes into account the service needs of an ageing and larger population suggests that Australia will need a net growth in the number of GPs of between 6,101 and 7,481 between 2006 and 2020. The wide range reflects the difference between the low and high population projections of the ABS. The projection implies an average annual growth of 435 to 534 GPs over the 14 year period to 2020. The authors assert that 'Australia has a workforce shortage of general practitioners, particularly in rural areas' and imply that this will continue.[35] Yet the current rate of increase in the FWE GP workforce, noted above, is more than 500 a year and is likely to increase in the next few years.

This argument is supported by a recently completed, but unpublished, review of the impact of the government programs intended to induce domestic medical graduates to work in the regional and rural medical workforce (such as the bonding program). The review, by Deloitte Access Economics, was commissioned by the Department of Health and Ageing. It concludes that these programs will lead to a significant improvement in the doctor to population ratio in rural and remote areas by 2020.[36]

4.3 If the shortage of GPs is diminishing, why are so many IMGs being recruited?

One obvious counter to the argument in this paper is that if shortages in the GP workforce are declining why are employers continuing to recruit IMGs to practise as GPs or to work as HMOs? As acknowledged, there are still some areas of shortage. But recruitment of both groups of doctors is continuing strongly in Victoria and NSW, despite the relatively comfortable population to FWE GP ratio in these states. In Victoria, for example, the headcount of FWE IMGs billing on Medicare increased from 1,493 in 2006-07 to 1,966 in 2009-10.[37]

It is likely that employers have adapted to the utilisation of IMGs and thus continue to employ them because they are a relatively cheap and compliant workforce. If an IMG is employed while on a 457 visa, it is difficult for the IMG to move to another employer. Furthermore, if they do, this will threaten their prospects of obtaining employer sponsorship for a permanent resident visa. There were 304 permanent resident visas issued to GPs under this visa subclass in 2010-11, almost all to IMGs working in Australia on 457 visas.[38] Why go to the expense of paying higher wages and providing better working conditions to domestic-trained GPs if there is a willing source of IMGs available?

There is a further possible motive to employ IMGs. For employers looking for a competitive cost advantage relative to established clinics which employ domestic graduates, the recruitment of an IMG workforce may provide this advantage. The case study of regional Victoria in Section 5.3 explores this hypothesis.

Section 5: Indicators of GP oversupply

5.1 Competition for GP Registrar training places

Six years ago there were more training places available for GP registrars than there were applicants for these places. The reverse is now the case. This is despite an increase in the number of places from 600 for the 2004 training year to 900 for the 2011 training year and 1,000 for those currently applying for the 2012 training year. There were 680 domestic applicants in 2010 for the 2011 training year, only 587 of whom accepted or received a place (domestic graduates may not have wanted a place in the rural program, which takes up more than half of the places available). In the case of the IMGs, there were 491 applications for the 2011 training year, 331 of whom received a place. For the 2012 training year, 841 domestic graduates have applied and 448 IMGs. Since they are vying for 1,000 places, many will miss out (though sometimes more places are allocated than the notional number).

5.2 Competition for Hospital Medical Officer positions

For the past decade or so, public hospitals have had to supplement their HMO ranks with IMGs, not just for general hospital work but also as trainees within specialist teams. There simply have not been enough domestic graduates to fill these positions.

This situation has changed. In Victoria, the State Health Department which is responsible for providing intern training positions had to provide about 400 such positions in 2006. By 2012 it is anticipated to have to provide for 690, because of the increased number of domestic graduates expected from medical schools in Victoria. The Health Department has to ensure there are enough places for domestic graduates from Victorian Universities, but not for other aspirants. As a result, for the 2010 placement round there were 209 applicants who did not get a place.[39]

The State Health Department also needs to fill the ranks of second and third year medical officers in the public hospitals as well. The current need is for about 500 to 600 doctors for each year. The number of domestic graduates is now sufficient to fill these needs as well. As a result, many candidates for these positions in Victoria are missing out on hospital positions.[40] They are mainly IMGs, because the State Health Department's first priority is to provide training opportunities for

domestic graduates. The experience at the Echuca hospital run by Echuca Regional Health illustrates the point. Two years ago the hospital employed 11 second and third year HMOs, of whom seven were IMGs. In 2011 just two IMGs were employed. There will be none employed in 2012. All HMOS will be domestic graduates. This experience is being repeated across Australia.

This is a significant development because as the registration statistics reported above indicate, at least half of the IMGs working in Australia on limited registration are doing so in the hospital workforce. Where HMO positions do become available, they attract very large numbers of applicants. From the point of view of the government subsidised recruitment agencies set up to deliver IMGs to the GP and hospital workforce, this competition has become a problem, because such IMGs often need preliminary training and supervision in the hospital setting. The Rural Workforce Agency of Victoria sums up the situation as follows;

> *There is an emerging trend of metropolitan and rural hospitals ceasing employment of OTD [overseas-trained doctors] HMOs as increasing numbers of Australian Medical Graduates emerge from tertiary institutions. These doctors are not always sufficiently experienced to enter the general [practice] pathways and there is a risk that there is a growing number of doctors who will be unable to practise.*[41]

5.3 The regional General Practice workforce, a Victorian case study

As the hospital option declines, IMGs anxious for work are converging on the one alternative available: GP positions. But because of the ten year rule, they have to find work in locations defined as districts of workforce shortage. This is true whether they are have limited registration and are on temporary visas or permanent visas, or whether they have come through the GP Registrar program or other avenues to obtain the RACGP or ACCRM Fellowship.

The rural workforce agencies set up to help locate IMGs to areas of workforce shortage are now also beginning to complain about the lack of GP places for them to fill. Health Workforce Queensland (HWQ), for example, complained in its submission to the House of Representatives Inquiry into Registration Processes and Support for Overseas Trained Doctors that there are now so many domestic graduates participating in the Bonded Medical Places Scheme (expected to exceed 4,000 by 2012) that: 'They will be competing with OTDs [overseas-trained doctors] for placements, making it more difficult for OTDs to obtain Area of Workforce Shortage positions'.[42]

As noted earlier, according to the latest Doctor Connect map of districts of workforce shortage, much of regional Victoria (other than in the big regional cities) is open to IMG registration on a limited basis, should employers wish to employ an IMG.

The response of employers needs to be understood in the context of the role that commercial organisations now play in the ownership of GP clinics in Australia. Such organisations have an interest in growing their business with new clinics. One constraint has been the availability of doctors prepared to work in such clinics. This constraint has been removed with the ready availability of IMGs anxious for GP work in districts of workplace shortage.

The legacy of past shortages of doctors in regional areas has left existing practices vulnerable to competition from clinics prepared to take advantage of this potential IMG workforce. Most regional Victorian GP practices require a co-payment above the bulk-billing rate. They usually bulk bill those

with Health Care cards but not other patients. Any new clinic which provides bulk billing services has a ready-made competitive advantage.

5.4 Tristar

There are several commercial organisations prepared to capitalise on this opportunity. The most active in regional Victoria is the Tristar Medical Group, whose headquarters are located in Mildura. Tristar began with the takeover of a practice in Warracknabeal. By 2008, Tristar had established 16 clinics across rural Victoria and NSW.

What makes the Tristar group significant for this inquiry is the speed with which it has expanded. It has not limited its operations to small communities where there have been chronic shortages of GPs. Rather it has expanded into relatively well served regional centres, including Bendigo, Ballarat, Portland, Swan Hill and Horsham. By July 2011 the 16 practices of 2008 had expanded to 29 (the great majority located in Victoria). The most recent of these, in Wodonga, opened in July 2011.

The clinics are predominantly staffed by IMGs. In 2008 Tristar indicated that about two thirds of the approximately 50 GPs employed were IMGs.[43] The organisation currently employs well over 100 GPs. It is not known how many are recruited directly from overseas on 457 visas, though Tristar states that it utilises this market directly rather than relying on the recruitment services of the Rural Workforce Agency of Victoria.[44] The managing director said in the context of the opening of the Wodonga clinic that getting doctors to regional areas 'can be tricky, but it [Tristar] hasn't had any major problems yet'.[45]

Tristar accompanies the opening of each new clinic with an advertising campaign advising residents that it provides bulk-billed services across extended hours, with no restrictions on access to the practice.[46] In doing so, the organisation provides GP services at a lower price than the competition.

Since the previous Medical Practitioners Board of Victoria has been willing to provide limited registration to IMGs in Victoria under conditions which allow multiples of doctors to practise under the supervision of each fully registered GP, Tristar has been able to operate on a low cost basis. This flexibility is about to be narrowed. But the new supervision rules, as noted, still allow each fully registered doctor to supervise up to four IMGs registered on a limited basis. The revenue stream generated may be substantial. As noted in Section 1.5, GP services billed in districts of workforce shortage are likely to attract vocational rates for each service, even where the GP providing the service is not vocationally registered. Tristar offers contracts to their employees in which they are paid 60 per cent of the revenue they generate.[47]

5.5 Implications for General Practice in regional Victoria

There are undoubtedly benefits for some patients, who as a result of the Tristar operation, now have more ready and cheaper access to GP services than was previously the case. The IMG-based workforce may also be an advantage for regional communities where there are substantial ethnic minorities.

Complaints from established clinics about the sudden upsurge in competition may be dismissed as special pleading; maybe as a form of medical protectionism. There may be something to this

reaction. Nevertheless, there are legitimate concerns about the consequences of this competition for medical care in the communities affected.

The implications of the Tristar model, which vacuums the routine GP services away from established clinics, have to be understood in the context of the way medicine is practised in regional and rural settings. This is quite different from metropolitan practices because regional GPs require a wider variety of skills than their metropolitan counterparts. This is partly because of the limited availability of specialist services. Because of this situation, the local hospital normally depends on GPs to provide procedural services, such as obstetrics and anaesthetics. The procedural work might provide 10 to 20 per cent of a GP's total income. Other income depends on the availability of routine GP work. If this work is not available, the ability to attract GPs with procedural skills will be threatened, as will the capacity of rural and regional hospitals to function effectively.

The capacity of rural and regional practices to provide training for registrars will also be undermined. Existing regional practices play a much greater role in education and training of registrars than is the case for metropolitan practices, because of the Australian government's policy to prioritise training and work in regional locations. For their part, some regional GP clinics have been keen to employ registrars in order to cope with patient demand. If the routine GP work is lost, this diminishes the established practices' capacity to take on registrars, since that is the basis of the registrar's income.

Regional GPs familiar with the Tristar operations were unanimous in expressing concern about the level of supervision of the IMGs employed. This is a legitimate concern given that most of the IMGs registered on a limited basis have not been subjected to an independent Australian assessment of their clinical skills. The question raised repeatedly by regional GPs was how can practices which employ few vocationally qualified GPs adequately supervise multiple numbers of IMGs, especially when the IMGs are working evening and week-end hours?

Section 6: What is to be done?

Australia is awash with GPs. Signs of oversupply are showing up in competition for places in the GP registrar program, in the difficulties that IMGs are facing in finding hospital jobs, in regional communities where new clinics based on IMGs are sprouting and in the statistics which show a sharp improvement in the population-to-FWE-GP ratios through much of non-metropolitan Australia since 2003-04. The rapid increase in the proportion of GP services which are bulk billed reached the very high level of 79.1 per cent in 2010-11 (up from 67.6 per cent in 2003-04). This is another impact of the recent growth in the supply of GPs. The peak bulk-billing rate occurred in 1996-97, when it reached 79.7 per cent.

This diagnosis is sharply at odds with the accepted wisdom in government, medical and media circles on the issue. Widely reported stories about continuing shortages of GPs in remote locations continue to feed the dominant paradigm, which is that there is a continuing shortage of doctors, including GPs.

It will probably come as no surprise that after months of submissions and hearings on the issue that South Australian MP Steve Georganas, the Chairman of the House of Representatives Inquiry into Registration Processes and Support for Overseas Trained Doctors, reached the following conclusions (as reported in the South Australian press) :

> *It was becoming apparent there was 'a great deal of tension' in the way the system operated for overseas trained doctors. He said with GP workforce shortages across regional Australia, and indeed within capital cities, 'These doctors play an important role in filling these spots' and doctors believed there was ' a lot of red tape, but it's there because we have such high standards'.*[48]

The submissions put to the Inquiry do suggest this conclusion. There is a noticeable absence of the information provided in this report. The medical authorities responsible for standards of GP practice, including the MBA, the RACGP and the AMC presented submissions. They all take a defensive stance, conscious that any robust defence of high standards would be likely to stir accusations of bias. None tell the Inquiry that they are presiding over a remarkably generous arrangement, which allows most IMGs from non-western medical schools to practise on a limited basis in Australia without having to satisfactorily pass an independent Australian assessment of their clinical skills.

Let us suppose that official thinking does take note of the emerging oversupply situation. The question then becomes what, if anything, can be done about it. The answer must reflect our findings about the decision-making process shaping the medical workforce.

The best place to start would be to remove the double standard on the assessment of domestic medical graduates and IMGs who wish to become GPs. The former must first complete the GP Registrar program. Their initial introduction to medical practice is closely supervised by accredited GP trainers during their three to four year registrar program. IMGs, however, can begin practising on limited registration without any independent assessment of their clinical skills, and under far laxer supervision rules than those applying to GP registrars. If this disparity were removed, it would slow the rate of appointments of IMGs to GP positions and bring Australian assessment standards into line with other developed countries.

There is a widespread belief in the wider public and within the medical workforce itself that the arbiter of assessment standards for GPs is the MBA. But it is not. These standards are the province of the Australian Health Workforce Ministerial Council, which includes each of the State and Territory Health Ministers. The Council has decided that in the interests of dealing with the alleged doctor shortage, IMGs, even if trained in developing countries, are only required to pass tests of English and of medical knowledge. If an additional test of clinical skills were to be added, it will require a collective decision of the Ministerial Council, following which each State and Territory will have to pass the required enabling legislation. Needless to say, this is likely to be a protracted process.

The MBA does have more freedom to recommend changes to the supervision rules required for IMGs with limited registration. These rules have to be approved by the Ministerial Council but do not require State and Territory legislation. There is a strong case for these supervision rules to be tightened, such that they parallel those required for GP registrars. This would, at a minimum, require a limit to the number of IMGs that can be supervised by an individual GP to no more than two and that the supervisor be accredited by the RACGP or ACCRM, as is the case for the GP registrar program.

6.1 Changes to migration regulations

Change could occur more quickly with reforms to the rules governing the issuance of permanent or temporary entry to IMGs. Given the very large number of IMGs already in Australia on such visas, thousands of whom are in the process of trying to gain employment as GPs, it makes no sense to add to this stock. The Australian Government's first obligation is to provide those already here with an opportunity to achieve the required standards.

The current migration rules need to be reviewed in this context.

1 IMGs entering under the permanent-entry skill-tested visa categories.

There were 1,010 visas issued to medical practitioners under these visa categories (known as the General Skilled Migration [GSM] program) in 2009-10 and 460 in 2010-11.[49] IMGs can only be visaed under this program if their occupation is on the Skilled Occupation List (SOL). This is compiled by Skills Australia (SA) and currently includes GPs. SA based its assessment on the record of employment of domestic medical graduates. Since almost all are finding employment as doctors and SA expects demand for Generalist Medical Practitioners to grow rapidly, they were included on the SOL. This judgement needs to be revisited urgently. It did not consider the situation of IMGs. This is where the oversupply lies and where it will increase if IMGs continue to be visaed at the current rate.

Unfortunately this not much that can be done to slow the inflow of IMGs entering via the back door routes, notably those visaed as spouses of successful principal applicants, those sponsored as spouses by permanent residents and those coming via New Zealand.

2 IMGs entering on 457 visas

There is no possibility that DIAC will review its practice of visaing all IMGs who employers sponsor for 457 visas. The 457 visa arrangements were deregulated in 1996. Employers do not have to prove that there is a need for the sponsored migrant, as by requiring evidence of labour-market testing. DIAC will issue a 457 visa to all persons sponsored by an employer, as long as they are skilled and as long as the sponsoring employer can verify that there is a job to be filled by the sponsored migrant.

However, DIAC will not issue a 457 visa to a doctor until the MBA has approved the applicant for limited registration. In turn, the MBA will not grant this registration unless the position has been classified by the Department of Health and Ageing as a district of workforce shortage and the relevant State or Territory Health Department has affirmed that it also meets its area of need criteria. This outcome means that the focus must turn to these determinations.

6.2 Area of need determination

It is appropriate that the present arrangements, which limit the areas in which IMGs can practise to districts of workforce shortage, stay in place. It is likely that domestic graduates will continue to be reluctant to practise in remote locations and thus that IMGs will be needed. Since all IMGs are aware that constraints on practice location are a condition for practice in Australia, this requirement is not unreasonable.

The problem with the district of workforce shortage policy is that the rules on which areas are so classified are opaque. It is hard to fathom how the Commonwealth can continue to classify large swathes of regional Victoria and NSW as districts of workforce shortage given the improvements in population to FWE GP ratios cited earlier. The rules by which states and territories make judgements about whether their area of need classifications match the Commonwealth's district of workforce shortage are even more impenetrable.

All that is known for certain is that the resulting decisions have resulted in the issuance of thousands of 457 visas for doctors each year. There were 1,190 issued for GPs in 2010-11 and 1,230 to Resident Medical Officers. Of this total of 2,420, nearly half were issued for positions in NSW and Victoria; 540 in NSW and 610 in Victoria.

A significant contraction in the areas classified as 'districts of workforce shortage' and 'areas of need' is justified. Since the Commonwealth pays the bill for services billed on the Medicare system, it can unilaterally curtail the range of locations eligible for IMGs to work in. A doctor cannot bill on the Medicare system without a provider number.

6.3 A new review of GP workforce needs

It is unlikely that the shortage paradigm will be challenged without an independent review of the GP workforce situation like the *Australian Medical Workforce Benchmarks* study of 1996 which was conducted by the now defunct Australian Medical Workforce Advisory Council (AMWAC). This was the origin of the 1,500 population-to-FWE-GP benchmark cited above. Another such independent study is required. It should be tasked to review the 1,500 benchmark. Is it obsolete? If so, what is an appropriate alternative? The study could then analyse how the distribution of GPs across Australia compares with the new benchmark.

The Commonwealth Government has established a very well resourced replacement for AMWAC. This is Health Workforce Australia. It should take on the task.

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