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Late Submission to the Senate Select Committee on Health

Here is some up to date analysis on GP workforce, which may be helpful to the Committee. It utilises data from 1984-85 to 2013-14 DoH workforce Statistics, published in December, as well as DoH Medicare data and Medical Training Review Panel reports. In the interests of brevity, the report is confined to a summary, some recommendations, and supplementary tables with commentary.

The 2002 GP workforce was estimated by AMWAC (2005) to be short of 800-1300 doctors. This equated to 121-123 per 100,000 population. Numbers are now 139/100,000 and growing fast. Parameters indicate oversupply since 2009. This is expensive and counter-productive to workforce dynamics. Overseas trained doctors in training outweigh the registrar training program by 32.5%, and receive little supervision by comparison.

Government policy needs to be much more nuanced and directed towards the long term than it is and has been. Oversupply and bulk-billing allow profiteering by employers. There is now a major conduit of OTDs from DWS to ASGC RA 1 Metro (917 in 2013-14) after completing 19AB moratorium. All OTDs exiting from DWS are immediately replaced. Oversupply has been evident since GPs exceeded 120/100,000 in 2009, and is part of a cycle of swinging supply set to continue indefinitely if appropriate action is not taken. It is sabotaging GP as a career for the 'tsunani' of ATDs, blocking off future practice.

Some recommendations:

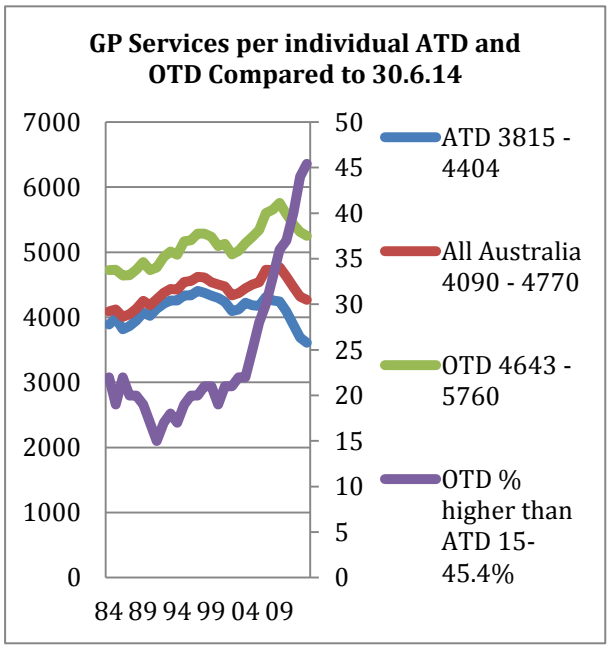
1. Vocational processes must reacquire priority. The workforce should be allowed to attenuate to 121-123 per 100,000 (essentially the level recommended by AMWAC in 2005). On this basis current over-supply is 3500 – 4000.
2. The registrar program intake be temporarily increased to 1750. The Metropolitan training program needs increasing to perhaps 1000, with some bias towards Perth, which is under-supplied.
3. Rural small-town programs need to be tailored to requirements. Towns over 50,000 are Metropolitan in profile.
4. Under no circumstances should commercial corporates be allowed their own training programs, a recipe for cost blow-out.
5. Registrar training programs need to be more tailored to requirements. Rural programs have special needs. Towns over 50,000 are definitely Metropolitan in requirements.
6. Entry to DWS be immediately suspended and reviewed to allow the present cohort of Non-VR GPs to wind down, with enforcement of 19AB moratorium requirements. Outer metro is now very adequately supplied and there has to be another solution to staffing of after-hours clinics. Large ASGC RA 2 towns are now highly over-supplied in numbers and have burgeoning numbers of corporate clinics employing OTDs.
7. A complete review of the needs of smaller rural towns (Monash Model 4-7), and policy directed to the generation of ATD generalists. This is a small workforce of perhaps 5-6,000 GPs. Most of these have hospitals which have hugely lost services through lack of appropriate GP policy. Regional training focus needs hugely more emphasis, with restitution of the Prevocational General Practice Placement program. Infrastructure and general subsidies need more realism. Data on this sector has yet to be collated. Conditions of DWS need to be tied to visiting hospital services, with measures to scale

back current flooding by community-only OTD corporates practices.

8. The AHPRA determine that the condition for unsupervised General Practice be approved Fellowship and not general or limited registration, with exceptions only for genuinely isolated situations. This would mean on-site supervision by approved Fellows for all pre-Fellowship doctors, easily accomplished if the workforce in training is adequately downsized.
9. The AMC scrutinise FRACGP pass rates, which in the high 80%s as opposed to 75% for other specialist colleges, and the desirability of supervision of community based pre-fellowship GPs.
10. Overall dynamics and role of General Practice especially in training of students and GPs needs to be much better factored in to workforce policy when considering political decisions like the co-payment. Whilst Corporates play little role in these matters and merit separate consideration, vocational practice is complex and much more central to the functioning of GP as a whole.
11. Entry to the workforce be through the training program, with ancillary arrangements for isolated locations unable to recruit fellows. Corporates would have to reorganise to supply metropolitan after-hours clinics with supervising Fellows. Contracted overseas doctors could be used under strict regulation to supplement numbers in the manner of Hospital ED rather than the current guarantees of permanent residence.

Summary.

Overall the workforce is in oversupply (139/100,00 population). It is commercialising. It has been reducing the vocational focus built up so effectively since the early 1990s. All this means overservicing and reduction in clinical capability. Until 2013-14, undersupply of Australian medical graduates meant low output of vocationally trained Australian trained GPs, with 25-30% of GP registrars sourced from overseas. Since graduate numbers are now adequate and ATDs score more highly than OTDs in Registrar entry tests, OTDs dropped to 17% in 2014. Registrars will soon be nearly all Australian trained. The 5209 practising 'non-Vocational' doctors, few not OTDs, at 30.6.14, generate as many fellows, with very little on-the job training by accredited teaching Fellowship-holders. This compares to 3932 registrars, 2815 acessing rebates, the rest doing hospital terms. At this time, 25.5% of Doctors accessing rebates are in training. In rural the rates are very much higher.

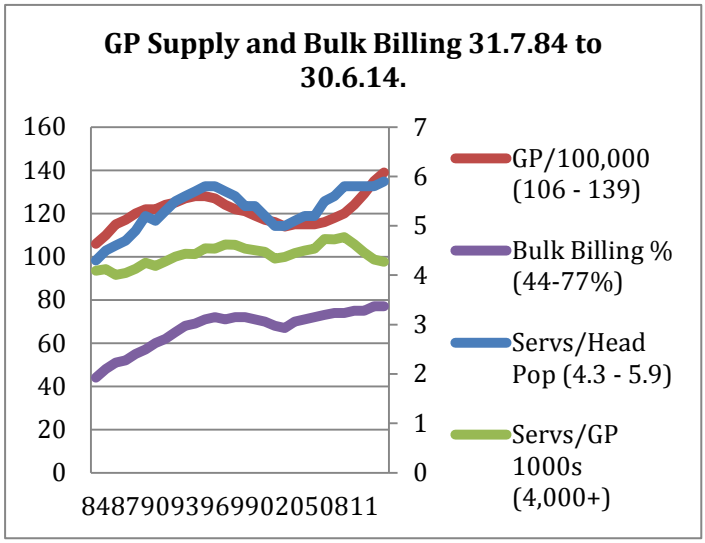


It is now 10 years since Government decided to facilitate an inflow of overseas trained doctors. In that time two workforces have developed, the vocational comprised mainly of Australian Trained Doctors, and the commercial comprised mainly of Overseas Trained Doctors. They have significantly different billing patterns. They accessed almost exactly half of Medicare rebates each in 2013-14, while comprising 59.9% and 40.1% of the workforce respectively.

Furthermore, OTDs accessed 45.4% more rebates per doctor than ATDs in 2013-14. This has developed since 2004, prior to which the differential had been 15-22% since 1984. This is not just a matter of increased access to doctors. Increased access to rebates especially occurs by splitting of management between visits. How much a doctor does this is a balance between individual vocational and commercial attitude, upon which a variety of factors impact. Sometimes it is in the patient's

best interest. Bulk billing very much encourages *management splitting* as does growth in GP numbers by creating *competition*. It is quite obvious from the second graph that services per doctor *increased* in two waves from 1984 to 1996 and from 2004 to 2009 as the number of doctors increased, despite alleged annual decrease in work hours.

In 2009 *oversupply* occurred and services per capita flattened out as GPs/100,000 passed 120. AMWAC recommendations in 2005, so carefully considered, were for a workforce equivalent to 121-123/100,000. From 2009 Services per GP started to drop. This was probably helped by increasing use of Extended Primary Care item numbers but must have been predominantly due to oversupply. Remember also that availability of specialists has greatly increased, and traditional GP territory is also being passed on, often with good reason, to allied health. As AMWAC observed, insufficient workload leads to deskilling. To improve population health and avoid hospitalization you need a smaller better skilled workforce remunerated enough to focus on difficult work and be content to pass on work to allied health. Likewise you need an appropriately sized specialist workforce that is not trying to take over areas of General Practice. We saw these things happening in the early 1990s when the workforce was similarly over-sized.



This is why we have put so much energy into developing vocational training, why we train our teachers and select them as stand-out GPs. This is why we insist that registrars have hospital experience in emergency and in acute paediatrics. I was a member of the JCC Paediatrics that decided the latter. We put huge energy into writing curricula for the FRACGP and the FACRRM. I was involved in both processes as were large numbers of motivated GPs. Unfortunately these standards have been jettisoned for the DWS OTD training program. The AHPRA has gone so far, in the current consultation, as to suggest that supervisors for limited registrant OTDs (1474 at 30.9.14) could have general registration only and just 3 years of experience in Australian General Practice. The AHPRA does not require any supervision for general registrants without fellowship (3735) either in DWS or non-DWS. Limited and General Registrants are not allowed to access Medicare Rebates outside of DWS.

These policies are disastrous in the long run for workforce standards and make a mockery of the vocational process. Rural doctors, so deeply involved in registrar and student training, have been extremely concerned at what they have witnessed, and made many complaints to RDAV during my tenure as Chair. AHPRA proved unapproachable and the matter was raised at the Victorian Legislative Council Inquiry (2014), which recommended the Minister follow up the matter of supervision with AHPRA.

The policies are also fiscally unsustainable. Workforce oversupply in the context of Fee for Service does not make fiscal sense. GPs and/or their employers can select their level of income within the tolerance of the Professional Services Review. The FFS system cannot survive without a vocational sense of responsibility and belonging. Extra servicing from commercial general practice would be at the very least $1/2b.

The Productivity Commission pays lip service to the concept of full workforce equivalence as well as AIHW. This looks good on paper. The part-time contributions of all GPs are summated to a 40 hour week by AIHW or an undisclosed Medicare earnings level by DoH. What you have in reality is diminishing earnings and FWE for ATDs, and sustained high level for a burgeoning OTD workforce (Tabled below).

The workforce is at capacity, especially OTDs. The number of patients seen by each vocationally registered OTD in ASGC RA 1 dropped from 7969 in 2012-13 to 7155 in 2013-14 consequent on the arrival of an extra 917 doctors from DWS, increasing their workforce by 19.6%. It also suggests that they are serving a restricted population, whether geographical or ethnic, rather than spread across the whole metropolitan population.

Whatever the truth of the matter, there is more than enough to suggest that some radical changes need to be made to the system as it currently stands. Medicare may well be at a cross-roads. Practical action is required and some effective genuinely long-term (10-20 year) policies need putting in place.

Tables: these provide extra information of potential use to the Committee. Notes have been provided to keep the above summary to minimum.

2009 – 2013 GPs/100,000, Services per Capita, Services per GP												
	GPs per 1000,000 Pop				GP Services per Capita				Services per GP			
	2009 - 2010		13-14	12-13	2009 - 2010		13-14	12-13	2009 - 2010		13-14	13-14
	State	Captl	State	Captl	State	Captl	State	Captl	State	Captl	State	Captl
NSW	117	119	128	123	6.1	6.5	6.3	6.3	5219	5506	4738	5045
Vic	118	119	135	125	5.7	5.9	6.1	6.1	4902	4984	4525	4719
Q	126	124	149	132	5.9	6.2	6.0	6.1	4720	5005	4052	4517
SA	135	136	152	141	6.0	6.2	6.0	6.1	4429	4585	3969	4238
WA	108	104	125	105	4.7	4.8	4.6	4.5	4325	4563	3727	4050
Tas	139	161	166	174	5.5	6.0	5.5	5.7	3963	3714	3296	3131
NT	120	127	245	163	3.2	3.5	4.0	4.3	1782	3500	1632	2981
ACT	110	125			4.4	4.6			3992	3651		
Aust	120	119	139	130	5.76	6.05	5.93	6.07	4770	5067	4270	4663

Note. Populations for 2013 remoteness areas by State have not yet been published by ABS so per capita attendances for State Capitals cannot be estimated. In line with general trends, services per GP have continued to decline in every State and State capital except Darwin, (where they have improved off a very low base), and ACT, (where OTD corporates have been opening up). Rates up to 6.3 per capita in Sydney illustrate potential for further increase. Rates in ACT and Perth of 4.6 and 4.5 suggest a potential for lower attendances. EEC rates for GP/100,000 have been published by Masseria. All were below 100 except for France, Belgium and Austria, which were higher than Australia. The England rate was 71 in 2014 (Pulse) with aspiration (CFWI) to rise to 84 by 2030. England does properly supplement GPs with Practice Nurses.

	2013-14 GP Supply of doctors accessing rebates by ASGC RA from DoH workforce data													
ASGC RA	Pop.	GPs	GP /100.0	FTE /100.0	FWE /100.0	FWE %	VR %	Non VR %	ATD %	OTD %	Fem-ale %	Reg %	Servs PC	Servs /GP
1	16503	21498	130	84	101	77	82	12	57	43	44	5.8	6.07	4663
2	4217	6487	154	93	106	69	64	20	58	42	42	15.4	6.08	3952
3	2067	3057	148	78	90	61	59	27	62	38	39	14.2	5.14	3482
4	323	734	223	70	73	32	68*	32	60	40	31		3.94	1734
5	209	625	299	51	52	17	73*	29	62	38	41		2.73	914
2-5	6816	10903	160	54	58	61	66*	23	60	40	41			
Tot.	23319	32401	139	83	99	72	73	16	58	42	43	8.6	5.93	4314

Notes. * includes registrars in RA 4-5. The very high rates against population in rural are noted. RA 2 includes large numbers of small rural towns with GP Hospitals. RA 3 includes large towns like Darwin, Kalgoorlie, Cairns, Townsville, MacKay, Geraldton. RA 4 includes Alice Springs. The small town rural workforce is quite small, possibly only 5-6,000, but merits always special consideration to guarantee equality of health provision and population health to the outer rural population. Large rural town GP generally has Metropolitan dynamics. The very high GP to population ratios in RA 4-5 reflect many part time GPs who are also not remunerated directly through Medicare.

Workforce inputs – Registrar training and OTD recruitment							@ 30th June				
Year	Reg Intake	DoH Reg.	MRTP Reg.	All New Fellow	GPET New F.	Non GPET New Fell.	Non-VR	ATD VR	OTD VR	OTD VR +/-	OTD VR %
2015	1445										
2014	1272	2815					5209	16580	7797	-73	31.8
2013	1167	2458	3932				4672	16391	7870	+1423	33.5
2012	1046	2127	3289	1279	643	636	4410	16027	6447	+744	28.7
2011	918	1867	2968	1075	553	552	4150	15959	5703	-18	26.4
2010	749	1721	2572	863	439	424	3970	15201	5721	+824	27.3
2009	684	1542	2309	968	407	561	3754	15534	4897	+517	24.0
2008	594	1448	2162	841	510	331	3702	14373	4380	+380	22.7
2007	619	1370	2003	613	412	201	3564	15338	4000	+344	20.7
2006	558	1309	2003	628	407	221	3586	15378	3636		19.2
Total				6267	3371	2926 – 47%	+1625	+1202	+4161		

Note: The two entry points for Fellowship training are **registrar training** (all ASGC RA sectors) and Community based **'practice eligible' training** in District of Workforce Shortage DWS (also all sectors). *Sources*: MTRP 10-17th reports, DoH GP statistics, GPET info per Robert Hale. MRTP information is delayed by several years. Increases in VR ATD and OTD are net of attrition which is more for ATDs (up to 2.5%) because of longevity and less for OTDs (below 1% at present). Non-VR doctors appear to be OTD for all intents and purposes, especially in Metro, though there are a few ATDs gaining fellowship in DWS under 19AA exemption outside the training program. This chart demonstrates rise of non-GPET program of Fellowship acquisition and rise of VR OTD from 23.6 to 47% of all VR since 2006. RACGP FAEG (Fellow ad Eundum Gradum) figures are available for 2012 only. It can be noted that there has been world-wide condemnation of active recruitment of doctors by richer from poorer countries. On the RHS of the table figures are for the end of financial year for comparison so eg 2013 becomes 2014.

GP Actual Workforce and Population growth compared 2004 -13								GP	Servs.
Year	Total in GP	GP +	GP + %	Pop. 100,000s	Pop. +	Pop. + %	Diff. %	/100.0	/ PC
2004-5	23376	429	1.9	20395	268 (1000)	1.3	0.6	116	5.15
2005-6	23384	456	2.0	20698	303	1.5	0.5	117	5.25
2006-7	24272	438	1.8	21916	318	1.5	0.3	117	5.29
2007-8	24903	631	2.6	21384	368	1.8	1.2	117	5.54
2008-9	25276	823	3.3	21779	395	1.8	1.5	119	5.60
2009-10	26613	887	3.6	22065	286	1.3	2.3	121	5.76
2010-11	27639	1026	3.9	22183	118	0.5	3.4	125	5.77
2011-12	29011	1372	5.0	22485	302	1.4	3.6	129	5.75
2012-13	30861	1670	5.8	22906	421	1.87	3.9	135	5.78
2013-14	32401	1720	5.6	23319	413	1.77	3.83	139	5.93

Note. The HWA does not have appeared to have used DoH figures in assessing it's 'expressed demand' level at 3.2% GP workforce growth above population growth. Even this level is currently exceeded by OTD importation. No basis was published for this figure with no discussion of international experience or basics of GP workforce supply. There is a question as to whether DoH is adjusting DWS to achieve this quota.

Australian Supply of Primary Care doctors accessing rebates from DoH workforce data														
		Per 100,000 pop.			As % of total Numbers									
Year	GPs	GP	FTE DoH	FWE DoH	FTE %	FWE %	VR %	Non VR %	ATD %	OTD %	Fem-ale %	Reg %	Servs PC	Servs /GP
'13-14	32401	139	83	99	60	72	75	16	59.9	40.1	43.2	8.6	5.93	4270
'12-13	30681	135	80	96	60	72	76	16	62.6	37.4	42.4	8.0	5.78	4315
'11-12	29011	129	78	94	60	73	77	15	65.7	34.3	41.7	7.3	5.75	4463
'10-11	27639	125	76	91	61	73	78	15	64.0	36.0	40.8	6.8	5.77	4429
'09-10	26613	120	75	90	62	74	79	15	65.5	34.5	40.0	6.5	5.76	4770
'08-09	25726	119	74	89	62	75	80	15	66.4	33.6	38.5	6.1	5.60	4725
'07-08	24903	117	73	88	62	75	79	15	67.5	32.5	38.7	6.0	5.54	4732
'06-07	24272	117	73	87	62	75	80	15	68.8	31.2	33.1	5.6	5.29	4538
'05-06	23834	117	72	88	62	74	81	15	69.7	30.3	37.4	5.5	5.25	4502
'04-05	23378	116	72	86	62	74	80	15	70.1	28.9	36.9	5.1	5.15	4447
'99-00	23147	121	73	86	60	71	75	21	74.6	25.4	34.2	4.1	5.52	4538
'94-95	23102	128	74	87	59	70	89	26	76.1	23.9	31.1	5.5	5.68	4426
'89-90	20751	122	65	76	55	65	24	75	77.0	23.0	27.4		5.16	4252
'84-85	16659	106	56	66	54	63	0	100	76.0	24.0	22.7		4.32	4090

Note. This shows the rise and fall of supply, and the rise in DoH workforce equivalence against population, which did not fall during shortage, with rises lately reflecting OTD not ATD activity. Proportion of main subgroups are listed, together with services per capita and average GP services.

Average Annual workforce increase as % of workforce (Year beginning 1st July).						
	1984 - 89	**1990 - 94**	**1995 - 99**	**2000 - 04**	**2005 - 9**	**2010 - 13**
All GPs	4.8	2.4	0.4	- 0.2	2.7	5.2
ATD	4.6	2.0	3.8	- 0.4	- 0.9	2.7
OTD	3.3	2.8	2.1	3.2	6.1	8.9

Note: demonstrates boom/bust cycle of GP workforce provision. This creates instability in the workforce. The shortage period has led to a loss of mid-career numbers available for teaching, leadership, practice ownership, and representation. The 2004 response to shortage has been most favorable to the growth of corporates.

Average Annual Medicare Rebated Services by Doctor per category since '09

Category	**2008-9**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
All	4725	4770	4629	4463	4349	4270
Male	5569	5615	5474	5291	5115	5063
Female	3436	3505	3406	3307	3227	3227
ATD	4256	4248	4092	3745	3688	3609
OTD	5653	5760	5586	5429	5312	5252
VR	5179	5241	5111	4945	4805	4767
ATD VR	4613	4644	4546	4382	4262	4142
OTD VR	7561	7688	7374	7089	6919	6770
ATD Metro VR	4613	4644	4544	4382	4262	4137
OTD Metro VR	7898	7892	7552	7359	7969	7177
Non-VR (OTD)	3159	3226	3085	3002	2925	2981
Registrar	2540	2615	2492	2414	2332	2334
Under 35	2720	2665	2479	2350	2277	2308
35 to 44y	4433	4518	4337	4167	4078	4051
45 to 54y	5340	5394	5281	5153	4998	5042
55 to 64y	5388	5444	5339	5167	5034	4984
65 to 74y	4449	4500	4424	4365	4237	4250
75+	2499	2528	2665	2663	2713	2661

Note. All groups have shown a decrease in services per GP since what appears to be a ceiling of demand was reached in 2009. *The exception* however is Metro OTDs with Vocational recognition, who have fluctuated at very much higher levels than VR ATDs, accessing as many as 9152 rebates per doctor in 2003-4. Their spike in rebates in 2012 coincided with a reduced intake of VR OTD doctors to Metro and the reduction in 2013-14 coincided with a major increase in this number. This shows the effect of competition and it also suggests that they are geographically or ethnically concentrated in parts of RA 1 rather than diffusely spread across it, in other words that greater accessibility is in these populations only.

All Australia GP Full time equivalence (DoH) as a percentage of total doctors compared for ATD and OTD											
	All			ATD				OTD			
Year	All	FTE %	FWE %	All	% All	FTE %	FWE %	All	% All	FTE %	FWE %
'13-14	32401	61	72	19395	59.9	54	62	13006	40.1	68	86
'12-13	30681	60	72	18839	61.4	54	63	11842	38.6	69	86
'11-12	29011	61	73	18154	62.6	56	65	10857	37.4	69	86
'10-11	27639	61	73	17686	64.0	57	66	9953	36.0	69	86
'09-10	26613	62	74	17422	65.5	58	67	9191	34.5	70	88
'08-09	25726	62	75	17075	66.4	58	70	8651	33.6	70	87
'07-08	24903	62	75	16821	67.5	59	69	8082	32.5	69	87
'06-07	24272	62	75	16708	68.8	59	69	7564	31.2	69	86
'05-06	23834	62	74	16612	69.7	59	69	7222	30.3	68	85
'04-05	23378	62	74	16571	70.9	60	70	6807	29.1	68	84
'99-00	23147	60	71	17259	74.6	59	68	5888	25.4	64	78
'94-95	23102	57	68	17583	76.1	56	66	5519	23.9	61	75
'89-90	20751	53	63	15920	77.0	52	60	4781	23.0	58	71
'84-85	16659	53	62	12662	76.0	48	59	3997	24.0	60	72

Note. 'ATD' includes Registrars. 'OTD' includes registrars and Non Vocational OTDs. Actual figures for Vocationally registered ATDs and OTDs are therefore higher, especially OTDs. '% All' of ATD and OTD is given as a % of total number. FTE and FWE are given as a % of that group. This table demonstrates the much higher % of OTDs achieving 'full workforce equivalence' as defined by DoH although the

number is diluted by Non-VR OTDs. The FWE % for VR OTDs is near 100%. The medical profession relies on FTE estimates by **AIHW** annually based on self-reporting of hours worked by doctors at registration. This means a snap judgment based on self-image and and of questionable reliability. These have not offered a consistent set and in some years whole States have been missing. In the earlier 2000s, when documented self-reported hours worked were dropping, rebates per doctor were rising. **DoH GP workforce statistics** for doctors accessing GP Medicare rebates, not used or accepted by the medical profession, appear to be completely reliable and now correlate well with AHPRA numbers for Vocationally registered doctors, implying accuracy for non-VR doctors. DoH FTE and FWE estimations are based purely on rebates received and reflect numbers seen, not time spent, effectiveness or overall availability. In effect they reflect earnings and the capacity of the doctor to gain Medicare rebates. In the UK, FTE (37.5 hr week) roughly compares to Australia and is seen as an adjunct to workforce understanding rather than the principle goal of expansion.

Annual net increase (over and above attrition and outflow) of OTDs by sector											
Year	03-4	04-5	05-6	06-7	07-8	08-9	09-10	10-11	11-12	12-13	13-14
All	120	363	415	322	536	549	540	762	904	985	1164
% rise		5.6	6.0	4.5	7.1	6.8	5.9	7.7	9.1	9.1	9.8
Metro	14	228	306	154	265	401	347	406	546	228	1143
Rural	110	135	108	188	253	168	193	356	358	757	21

Note: This table demonstrates the very high rate of OTD workforce growth. The curious variations over the last 3 years may be due to DWS alterations, variation in RA 1 infrastructure availability, and end of 19ab moratorium periods. In 2013-14 Metro OTDs with Vocational Registration increased 19.6% by 907. These fellows were generated in Rural and Metro DWS and also substantial numbers of FRACGP "Fellow ad Eundum Gradum now entering (348 in 2012 is the only figure available, from Medical Training Review Panel 17th report).

OTD Specialist and Generalists with Section 19ab exemption (MTRP 14-17th reports)												
State	**2009-2010**			**2010-2011**			**2011-2012**			**2012-2013**		
	All	GP	GP%	All	GP	GP%	All	GP	GP%	All	GP	GP%
NSW	1584	933	**59**	1877	1147	**61**	2164	1301	**60**	3631	1579	**60**
Vic	1551	1045	**67**	1859	1272	**68**	2140	1477	**69**	2541	1724	**68**
Q	2025	1266	**63**	2159	1357	**63**	2477	1504	**61**	2855	1713	**60**
SA	571	335	**59**	668	429	**64**	739	471	**64**	866	534	**62**
WA	775	505	**65**	892	579	**65**	1003	643	**64**	2397	842	**65**
Tas	233	121	**52**	260	136	**52**	302	154	**51**	365	195	**56**
NT	147	102	**69**	161	107	**66**	192	126	**66**	226	145	**64**
ACT	85	29	**34**	99	39	**39**	161	65	**40**	189	85	**45**
Total	6576	4157	**64**	7461	4809	**64**	8455	5403	**64**	9931	6330	**64**

Note. These figures are published annually in MRTP reports. They do not include 19AA exemptees with citizenship or permanent residency. The curious consistency of GP proportion is difficult to explain without adjustment of DWS quotas, which could be the case given great over-supply in RA 2-3. This is also supported by the surprisingly high ASGC RA 2-5 GP to population ratios. If the number of Non-VR OTDs at the time is subtracted from each of these years, the number of OTD fellows 'in waiting' (to transfer to Metro in most instances) would have been, 187, 159, 943 and 1568, showing quite a build up. The 2013-14 increase in OTD Metro Fellows of 917 suggests that many of these had already served out rural moratorium periods and so were able to transfer soon after Fellowship.

ATDs by RA (DoH Stats)								Metro VR ATD
Year	**All**	**RA 1**	**RA 2**	**RA 3**	**RA 4**	**RA 5**	**RA 2-5**	
13-14	19395	12804	3608	1581	451	384	6035	12057
12-13	18839	12606	3553	1644	454	370	5548	11726
11-12	18154	12377	3331	1432	415	349	5309	11677
10-11	17686	12318	3265	1341	354	282	5104	11556
9-10	17422	12202	3161	1337	324	209	4873	11575
04-05	16571	11962	2953	1230	247	177	4607	11461
99-00	17259	12619	2964	1280	258	140	4642	12119
94-95	17583	13278	2825	1208	209	63	4305	12421

89-90	15970	12134	2464	1108	198	46	3816	
84-85	12662	9611	2008	867	139	37	3051	

Note. Figures are net of attrition which is around 2.5%. Are we training enough ATDS? ATDs include ATD registrars. Registrar total numbers have risen to 3932 from 2003 since 2006. Metro registrars have been almost entirely ATD, which allows calculation of VR ATD for Metro, which jumped a bit in 2013-14 after years of low growth, showing that training programs are kicking in. Growth in the regions has been aided by increased registrar numbers and confirms that this is an effective approach. However there was a worrying and unusual drop in RA 3 ATD numbers in 2013-14. It would make sense to gradually adjust Metro registrar training rather than conduit OTDs through rural to improve RA 1 numbers. Numbers in the Metro training program are not enough at the moment. An increase is warranted especially in WA, where Perth is very undersupplied compared to the other State Capitals. This will deprive the rural program initially of ATDS but hopefully that will build up.

Medicare benefits paid and fees charged Financial year 2006-13. DoH Medicare Statistics										
		Benefits Paid per GP $*			Fees charged per GP $			Per FWE doctor $		
Year	T. GPs	Total $b	Per GP	%+	Fees Chgd	Per GP $	%+	T. FWE	Benefit	Charged
'13-14	32401	6350610	196.0	1.2	7043026	217.4	0.8	23174	273.8	303.7
'12-13	30681	5939320	193.6	0.7	6611073	215.5	0.5	22087	268.9	299.3
'11-12	29011	5577082	192.2	1.0	6223177	214.5	0.9	21119	264.1	294.7
'10-11	27639	5261402	190.3	1.9	5875894	212.6	2.0	20267	259.6	289.9
'09-10	26613	4968860	186.7	0.7	5546385	208.4	1.1	19729	251.9	281.1
'08-09	25276	4685913	185.4	3.3	5210271	206.1	3.8	19231	243.7	270.9
'07-08	24903	4466828	179.4		4946557	198.6		18643	240.0	265.8
6 yr +	30.1%	42.2%	9.3%		42.4%	9.5%		24.6%	14.1%	14.3%

Note. This analysis uses only medicare benfits from DoH Medicare Statistics and does not include other expenditures on GP. *"Total Benefit paid, in and out of hospital GP/VR GP, EPC, other, Practice Nurse Items". Fees charged are presumably calculated from patient rebates. The net gain to the GP is less than might be expected except in high turnover situations. However it does translate into out of pocket expense of $26-82 per rebate. The cost of rebates rose 42.2% between 2007-8 and 2013-14 by a total of $1,883,782 per annum, while population rose by 9.0%. Cost per Capita rose 25.1% from $215 to $269. Fees actually charged in 2013-14 amounted to $217,400 averaged for each doctor, and $303,700 for each FWE doctor. Individual rebates averaged $45.91 per rebate with fees charged $50.92. Assuming a BB rate of 77%, this calculates at $77.84 average for each fee charged privately, leaving the individual out of pocket by $26.92.

Cost of GP Medicare rebates per capita $ by ASGC region. DoH Medicare Statistics							
	2008-9	2009-10	2010-11	2011-12	2012-13	2013-14	5y Increase
Total	216	225	235	245	256	270	25.0%
RA 1	227	235	244	254	265	279	18.7%
RA 2	214	226	240	254	269	321	50.0%
RA 3	186	198	210	226	240	256	37.6%
RA 4	162	169	178	186	196	208	28.3%
RA 5	114	124	133	141	155	166	45.6%

Note. The jump in per capita costs for RA 2 is at first sight surprising because although GPs are in super-abundant supply, per capita attendances have gone only to Metro levels. It represents a sobering possibility for potential Medicare expenditure. The only way that this expenditure could occur is by excess use of EPC item numbers combined with otherwise high servicing rates as demonstrated for Metropolitan VR OTDs. There has been a major increase in corporates utilizing OTDs in RA2, facilitated by AHPRA tolerance of low supervision levels for limited registration OTDs, allowing clinics with no Fellows on site. **Sources**; Population from ABS. Costs from DoH Medicare Statistics Tables 2 and 11-15, total Benefit paid.

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