Submission: AHPRA Public consultation on the draft revised *Guidelines – Supervised practice for international medical graduates.*

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[redacted]

The author, a UK graduate, has been an ASGC Remote Area 3 rural generalist and obstetrician since 1985. Experience has included membership of the inaugural JCC Paediatrics, member Australian Paediatric Review, editor Emergency Paediatric Review, President Rural Doctors Association Victoria and member RDAA Board 2004-2013, Hon lecturer Monash RCS, Provincial Health Officer and Senior Health Planner in Papua New Guinea. As a practicing rural generalist, he has extensive experience in teaching medical students, registrars and Overseas Trained Doctors. He is an independent GP workforce researcher.

The GP workforce is now in gross supply, because of in-migration combined with increased registrar training. It is suggested that the AHPRA put on hold any further measures to facilitate the IMG influx by further reduction of supervision standards as proposed in the draft guidelines. The proposal in particular for supervisors not to hold Fellowship, and for supervisor approval to be based on 3 years experience of Australian General Practice and General registration, would not be acceptable to any registrar supervisor in the Registrar Training Program.

Workforce Statistics for doctors accessing GP rebates are available, from the annually updated DoH database[1] to 30.6.14, in much greater detail than AIHW. The 2005 AMWAC Report[2] advocated workforce numbers equivalent to 121-123 per 100,000 population (total numbers). The current level is 139 and rising fast. In ASGC RA 1 (Metro) the ratio is 131, in RA 2 154 and in RA 3 148. In England the ratio in 2014 was 71.1[3] with thoughts only of a rise to 83-4.[4] England looks at Full Time Equivalence as part of the picture but not an end in itself. The recent preoccupation with high FTE over gross numbers is peculiar to Australia. Levels of FTE have risen but this is due solely to the activities of IMGs, who have increased DoH full workforce equivalence FWE from 84 to 86% since 2004 despite up to 40% being non-vocationally registered. GPs medically graduated in Australia have reduced FWE from 70 to 62% over the same period, with only about 9% registrars accessing rebates.

This is not an argument for bolstering workforce with overseas recruits. Australian trained GPs with Vocational Recognition have an immense capacity for effective and economical management of patient conditions and for reducing unnecessary visits to the doctor. Calculating from DoH statistics, IMGs, including those without vocational recognition accessed in 2013-14 on average 46% more rebates than ATDs, more than doubling the difference since 2004. The difference calculated for IMGs with Vocational Recognition against VR ATDs in ASGC RA 1 (Metro) was 71%.

The Fiscal consequences have been evident. The total costs of Medicare rebates[5] have risen by 42.2% over 6 years. The total cost of rebates per capita of population has risen 25%, 19% in Metro and 50% in RA 2. These costs relate to levels of servicing. Population has risen by 7.5%[1]. Rebate levels have been held back against inflation.

AHPRA sets levels of supervision for, and gives registration to Limited registration doctors in State approved Areas of Need. These areas are valid only if they are also approved Districts of Workforce Shortage. These doctors are, as are DWS doctors

with general registration, exempt from the legislative requirement to have Fellowship to access Medicare Rebates under section 19AB(3) of the Health Insurance Act. The total number of doctors accessing GP rebates with 19AB approval in 2012-13 was 6330.[6] This included 4762 without vocational recognition, the remainder presumably being IMGs with fellowship serving moratorium periods. In 2012 there were 643 GP Fellowships obtained within GPET and 636 within the non-Registrar IMG community.

DWS includes fringe metropolitan and metropolitan after-hours clinics. At 30.6.14 51% of the 5209 doctors without Vocational recognition accessing GP rebates were in RA 1, the rest being in RA 2-5. IMGs do not enter the RA 1 vocational workforce except from DWS or from the RA 2-5 registrar training program, there being few IMGs in the RA 1 GP registrar program. In 2013-14, the RA 1 IMG VR workforce grew 20% by 917. This means that a large number of fellows left RA 2-5 and quite likely also relocated out of fringe metropolitan DWS. Obviously this compromised supervision capacity in Corporates employing Limited Registration IMGs.

Corporates employing IMGs are allowed to sequester and keep large numbers of positions in DWS. Because of superior size and organisation they are able to devote resources to a chain of employment. In this manner there is now a continuous flow of IMGs through DWS to RA 1, the ideal and financially most rewarding destination prior to any proposed reductions in rebates. Although the number of limited registrants is falling, to 1474 in September[7], the number of general registrants is rising considerably, judging by rapid rise of non-Vocational doctors accessing Medicare GP rebates. These pre-fellowship registrants are exempt from the 1 on 2 physical supervision required of registrars, despite not having the presumed higher level of training at school, university and the hospital system received by ATDs. They also escape the acute paediatrics and emergency experience required of registrars, which to many is ominous for patients with occult serious acute conditions.

The GP workforce was 32401 at 30.6.14.[1] As envisaged by AMWAC in 2005[2] it would have been between 28,216 and 28,676. This means an oversupply now of 3500 – 4000 (12% of workforce). Only 3 other countries were listed with more than 100 per 100,000 in 2006.[8] The suggestion by HWA in 2012[9] that GP Workforce growth should be 3.2% ahead of population growth ("expressed demand") was not substantiated and appears grossly and progressively excessive. The number of registrars and non-vocational doctors accessing rebates totaled 8024 at 30.6.14, or 24.8% of workforce. This figure is higher if Registrars working on hospital rotations are included. These doctors are all in training. Apart from producing a workforce unnecessarily high for population health needs, the reduced level training being given is unavoidably reducing overall standard of the workforce. Oversupply itself leads to diminished capability through less work and focus on commercial rather than vocational priorities.

The 2011 AHPRA Standard for the supervision of Limited registrants was established without a consultation process. It sacrificed the GPET norm of 1 on 2 physically mentored training by very well qualified and experienced supervisors. The results have not been positive for the vocational ideal and are probably fiscally unsustainable within the Medicare system. Any further dilution of supervision will only worsen the situation. GP training should only be conducted by GP Fellows, who themselves must

have been physically trained by GP Fellows, both of referenced quality.

The overseas recruitment program needs winding right back, and it is a mystery to the author and many others why the Medical Boards supported it in its present form in the first place. The registrar training program is more than adequate at present for keeping pace with workforce attrition and population growth of 1.8%. The rural problem, which stimulated the Limited Registrant program in the first place, requires new approaches that do not generate workforce excess in numbers as is presently happening. It is within the compass of the AHPRA, in cooperation especially with the AMC, to resist the desire of government to create greater accessibility of GPs by reducing standards, and it is earnestly recommended that this be done. OTD General registrants need supervision and training as much as ATDs. This can only be achieved by reducing numbers. An endpoint fellowship examination is not enough to ensure vocational attitude and capability. Examinations themselves are very susceptible to technique, a much discussed topic at this time.

It will take 20 years to produce steady input with uniform standards that enable a genuinely systematic and qualitative approach to GP workforce. That process has yet to begin anew. It was formerly frustrated by lack of graduates. The present glut will lead to shortages later. Now that graduate output has been addressed, all major players, including the AHPRA, need coordinated commitment and process for the situation to be redressed.

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References.

[1] DoH GP workforce annual statistics. Also provides population estimates.

[2] Australian Medical Workforce Advisory Committee (AMWAC) Report: GP Workforce in Australia 2005 – 2013. This was the last major Australian review written with quality in mind.

[3] UK Health Social Care Information Centre quoted Pulse 24.12.14.

[4] (UK) Centre for Workforce Intelligence CFWI March 2013 'GP In-depth Review'.

[5] DoH Medicare Statistics. Productivity Commission figures are greater but rely on unpublished DoH data.

[6] Medical training Review Panel Reports provide numbers for DWS 19AB but not AON or 19AA.

[7] AHPRA Medical Registrant data

[8] Primary Care in Europe Masseria et al. LSE Dec. 2009

[9] Health Workforce 2025 Vol 3. HWA 2013. Underlying reasons for projections were not fully detailed.