26 June 2009

SUBMISSION BY PRIMARY HEALTH CARE LTD TO THE ACT LEGISLATIVE ASSEMBLY STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES INQUIRY INTO ACCESS TO PRIMARY HEALTH CARE SERVICES

A. REASONS FOR GP CLINIC CLOSURES AND GP SHORTAGES

1. There is a **7% to 9% p.a.** compound **increase** in the **need for health care services**.

2. This increase in need is due to a **combination of factors**:

   2.1 **Increase** in total population numbers.

   2.2 **Increase** in the age of the population (increasing age results in increasing need for care).

   2.3 **Increase** in technology which leads to:

   (a) Increase in knowledge of diseases.

   (b) Increase in sophistication of care.

   (c) Increase in range of care.

   (d) Increasing availability of care for many diseases.

   2.4 **Increase** in the expectation of patients for their health care, due to:

   (a) Education of patients and population.

   (b) Wealth creation (higher socio-economic groups tend to have a greater awareness of and utilisation of health resources).

   (c) Promotion of health care by multiple groups, including:

   (i) government;
   (ii) not-for-profits, and other groups;
   (iii) "for profit" companies (e.g. CSL promotes vaccinations etc);
   (iv) the media (as part of generating revenue for themselves, the media report "panics", "pandemics", deaths of "stars" and well known persons from cancer, and similar stories, with a resultant increase in the demand for and use of health care resources).

2.5 **Promotion of "ill health"** activities by "for profit" entities in:

(a) Tobacco industry (legal)

(b) Alcohol industry (legal)

(c) Motor vehicle industry (legal)

(d) Fast food, confectionary industries (legal)

(e) Drug industries (illegal).

2.6 **Increase in government "red tape"** that is unique to general practice, which leads to:

(a) increase in GP practice costs; and

(b) decrease in GP availability,

as evidenced by:

(i) The Productivity Commission concludes in its Research Report "General Administrative and Compliance Costs" dated 31 March 2003, at page 61, that the national general practitioner administrative costs of participation in Commonwealth Government programs that impact specifically on general practice (as opposed to programs that apply to businesses generally) is $16,100 per annum per general practitioner. Based on the figure of $63.84 per hour for general practitioners that the Productivity Commission used (see page 55), this equates to 252 hours per annum. This is more than 10% of a busy GP's time (a busy GP doing 50 hours x 48 weeks = 2,400 hour per annum).

(ii) The Productivity Commission in that Research Report noted, at page 39, that there was, in addition, "anxiety, stress and frustration due to the accumulation of many government requirements; resentment at having to complete seemingly unnecessary forms; and tension between the roles they perform on behalf of patients and government departments."

2.7 **Response of government** to these demands and needs over the last two decades are as follows:

(a) **Reduction** in training of new health care providers[1].

(b) **Reduction** in the intake of overseas trained healthcare providers, via various barriers of entry.

(c) **Reduction** in allocation of provider numbers for GPs in training, nil for one to six year interval (Wooldridge, Minister for Health).

(d) **No intake** of medical trainees for one full year (Wooldridge, Minister for Health).

(e) Expansion of the time required for training programs for general practitioners to create an **effective reduction** in GPs.

(f) Change in university qualification from a primary degree to a secondary degree (that is, an individual needs to do an initial degree at the university and then do a medical degree) resulting in:

(i) Effective increase in time before graduation as a doctor; and
(ii) **Effective reduction** in number of graduates in medicine; and
(iii) **Effective reduction** in the working "lifespan" of graduates.

(g) **Reduction in the work and care provided by** a significant number of **general practitioners** throughout Australia to patients, **brought about by a combination of techniques used by Medicare Australia:**

(i) With the introduction of **"the 80/20 rule"**[2] very few general practitioners in Australia see 80 patients on 20 or more days in a 12 month period. However, Medicare knowing that the 80/20 rule is part

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[1] The fault for the current GP shortage lies squarely at the feet of the Commonwealth Government. The Commonwealth Government capped the number of places in medical schools in the mid 1990s to reduce the, then, perceived risk of a doctor oversupply (see Department of Health & Aged Care, August 2001, "The Australian Medical Workforce", Occasional Papers: New Series No. 12).

The cap remained in place until 2004 and, during this period, Australia fell within the bottom third of all OECD countries in the number of medical graduates per capita (see OECD, 2008, "Health Workforce & International Migration: Can New Zealand Compete?" Health Workforce Paper No. 33, p 27).

[2] From 1 January 2000 onwards, under s106KA of the Health Insurance Act 1973 (Cth) and the relevant regulation, a general practitioner is taken to have "engaged in inappropriate practice" if he or she does 80 or more professional attendances on each of 20 or more days in a 12 month period. This can lead to the complete disqualification of the GP from the Medicare scheme for up to 3 years (meaning that, for all practical purposes, he or she is banned from working as a GP) and repayment of money to Medicare. However, the GP is excused from exceeding this statutory "speed limit" if he or she can demonstrate that "exceptional circumstances" existed during the relevant period.

of legislation, actively pursues a campaign of threats against and intimidation of general practitioners throughout Australia who merely approach the "speed limit" encompassed by the 80/20 rule. This campaign by Medicare operates essentially as follows:

(aa) Medicare, through its well-publicised "Practitioner Review Program" actively targets general practitioners whose workload of patients generates 60 to 70 professional attendances per day, despite the fact that this is well below the statutory "speed limit".

(bb) In their targeted attack, Medicare presents the general practitioner with a data report and sets out in their letter to the general practitioner that Medicare has "concerns" as to whether the general practitioner is engaging in "inappropriate practice" or not providing sufficient care. Such allegations are based only on what a computer spits out, namely, that the general practitioner is doing say 70 attendances on 20 days in the past year. The alleged "concerns" have little to do with the skill and hard work of the general practitioner or the nature of his or her patients.

(cc) The next steps in the "Practitioner Review Program" involve:

(A) an interview by Medicare of the GP;
(B) a written report by Medicare on the interview;
(C) written submissions by the GP to justify himself;
(D) a further review by Medicare some months later to see whether the GP has "corrected" his or her behaviour so that "all the concerns" of Medicare have been addressed;
(E) if, after that further review, "some or all of the concerns" of Medicare remain, Medicare may decide to refer the hapless general practitioner to the Director of Professional Services Review.

(ii) **Medicare's heavy-handed strategy of alleged "concerns"** has led to **an Australia-wide reduction in the "expected" numbers of patients to be seen** per day changing from 80 to 70 per day to less than 60 per day, with many general practitioners who have never seen more than 60 per day also reducing their numbers as they have concerns (misplaced). There has been an estimated 15% to 20%

reduction in the work by the current general practitioner workforce throughout Australia.[3]
The Australian Institute of Health and Welfare has concluded that the drop in GP availability is largely a result of the measured decline in average hours worked by GPs (see **para 49** below).

(iii) Medicare's strategy in driving down GP hours is now being reinforced by **Medicare "audits"** for specific areas of care, such as care plans, nurse assisted items etc. This will accentuate Medicare's strategy, that is, i.e. less work done by general practitioners.

(h) **Reduced funding by the Commonwealth for general practitioner care:**

(i) Annual funding increases provided by the Commonwealth for the standard general practitioner consultation, which occurs at the start of November each year, has been about 2% per annum for many years.[4]

(ii) This contrasts with cost increases in general practice of about 5% per annum and a background of CPI increases of 3.3% per annum compound.[5]

(i) **Increase in government "red tape".**

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[3] To put it bluntly, for every 10 FTE GPs that Medicare Australia causes, by its harassment and threats, to reduce his or her hours of rendering medical services by just 5 hours per week, results in the loss to Australia of one FTE GP for a whole year. The numbers are simple:

(a) 50 hours x 48 weeks = 2,400 hours per annum;

(b) 45 hours x 48 weeks = 2,160 hours per annum;

(c) the reduction is 240 hours per annum, which is 10% of a FTE GP's hours per annum.

[4] For the year end 30 June 2008 Medical Benefits Schedule Item 23 was the most common Item charged by GPs throughout Australia. There were 77,319,520 Item 23s and Medicare paid $2,531,423,016 in respect of them (average $32.74 per Item 23). The total of all "Group A1 General Practitioner Attendances" was 95,110,895, in respect of which Medicare paid $3,561,211,573 (average $37.44 per Item). See Medicare statistics at www.medicareaustralia.gov.au.

Over the 3 years to November 2008 the Commonwealth Government increased the Medicare benefit for Item 23 by only 6.68% (from $31.45 to $33.55).

[5] Over the 3 years to November 2008 the Consumer Price Index (All Groups) increased by 11.15% (from 149.8 to 166.5). See "G.2 Consumer Price Index" published by the Reserve Bank of Australia at www.rba.gov.au. For Canberra, that Index increased over that same 3 year period by 11.19% (from 149.7 to 167.5). See www.rba.gov.au.

Over the 3 years to November 2008 the Wage Price Index increased by 12.68% (from 106.5 to 120.0). See "G.6 Labour Costs" at www.rba.gov.au .

(j) **Increase in costs of managing patient records:**

(i) In December 2001 the Privacy Act 1988 (Cth) was extended to the patient records in the private sector throughout Australia. Since then, general practitioners have had to bear the added costs and time of the additional compliance costs, as well as dealing with requests for patient records, explanations to patients, and so on.

(ii) Despite the fact that the High Court of Australia (and other courts) have held that the medical practitioner owns the patient record, not the patient, governments have been happy to allow the community (the electorate) to believe that a patient's right of "access" to a patient record amounts to the patient owning the record. Further, government downplay that the patient is going to have to pay a fee to exercise their right of access.

(iii) The ACT Legislative Assembly has added further to the above burdens of a GP with respect to GP patient records by maintaining its own 53 page piece of privacy legislation that is inconsistent with the Commonwealth's Privacy Act 1988. To add to the complexity of the situation, as the Commonwealth's legislation "covers the field", under section 28 of the ACT (Self Government Act) Act 1988 (Cth) the ACT privacy legislation is invalid.[6]

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[6] The legislation that amended the Privacy Act 1988 (Cth) to have it extended to the private sector as from 21 December 2001 stated that its main objective was:

"to establish a single comprehensive national scheme providing, through codes adopted by private sector organisations and National Privacy Principles, for the appropriate collection, holding, use, correction, disclosure and transfer of personal information by those organisations" (s3 of the Privacy Amendment (Private Sector) Act 2000 (Cth)).

The Explanatory Memorandum in relation to the amending legislation, on the matters referred to above, stated:

"The Bill intends to establish a comprehensive national scheme providing for the appropriate collection, holding, use, correction, disclosure and transfer of personal information by organisations in the private sector. State and Territory laws that make provision for the collection, holding, use, disclosure or transfer of personal information will continue to operate to the extent that they are not inconsistent with the proposed Commonwealth legislation."

The Commonwealth has evinced a legislative intention to "cover the field" through the legislative amendments to the Privacy Act 1988 (Cth) that extended that Act to the private sector throughout Australia as from 21 December 2001. As a consequence, by the operation of section 109 of the Commonwealth of Australia Constitution Act (known as The Constitution) as interpreted by decisions of the High Court of Australia, any law of a State on the same topic, whether or not there is a contradiction between the State and the Federal enactment, is invalid.

While section 109 of The Constitution does not in its terms apply to the ACT, section 28 of the Australian Capital Territory (Self Government) Act 1988 (Cth) is similar in operation. It declares invalid a law of the ACT to the extent that it is inconsistent with, operationally, a Commonwealth law.

(iv) The ACT Government then declared, under its invalid privacy legislation, a maximum fee that could be charged to the patient for access that is 34% below the fee charged by the NSW Government.

(v) To compound the problem in the ACT, the ACT GP Taskforce issued a Discussion Paper on 19 June 2009 which, among other things, will play well with the electorate in relation to patient records but will inevitably lead to even more burdens and cost overheads for GPs in the ACT.

2.8 **Other non-government factors** include:

(a) Increase in the percentage of general practitioners who are **female,** with an associated increase in wastage of workforce availability (family life and alternative careers).

(b) Increase in **age of the general practitioner workforce,** with increased loss of general practitioner workforce hours through morbidy and death.

(c) **Social change**, arising from increasing apparent wealth over the last two decades, has led to an increasing emphasis on "lifestyle", with a reduction in work hours by young general practitioners.

3. The ACT Budget, presented on 5 May 2009, provides for a $12.2m investment, over 4 years for the "GP Workforce Initiatives."[7] This is tokenism.

4. Under the Council of Australian Governments reform agenda, the ACT Government has committed to regulatory reform to achieve the goal of a seamless national economy. Uniform regulation, throughout Australia, is a cornerstone of that commitment. In that context it is somewhat absurd to find that, in the case of general practice in the ACT, consideration is being given, in the GP Taskforce Discussion Paper released on 19 June 2009, to:

(a) maintaining the doubling up of legislation in the area of privacy, and then extending the inconsistency between the two sets of legislation; and

(b) bringing in new legislation, applicable only to general practice in the ACT, that just adds "red tape" that not only achieves no benefit at all, but also adds cost to general practice in the ACT.

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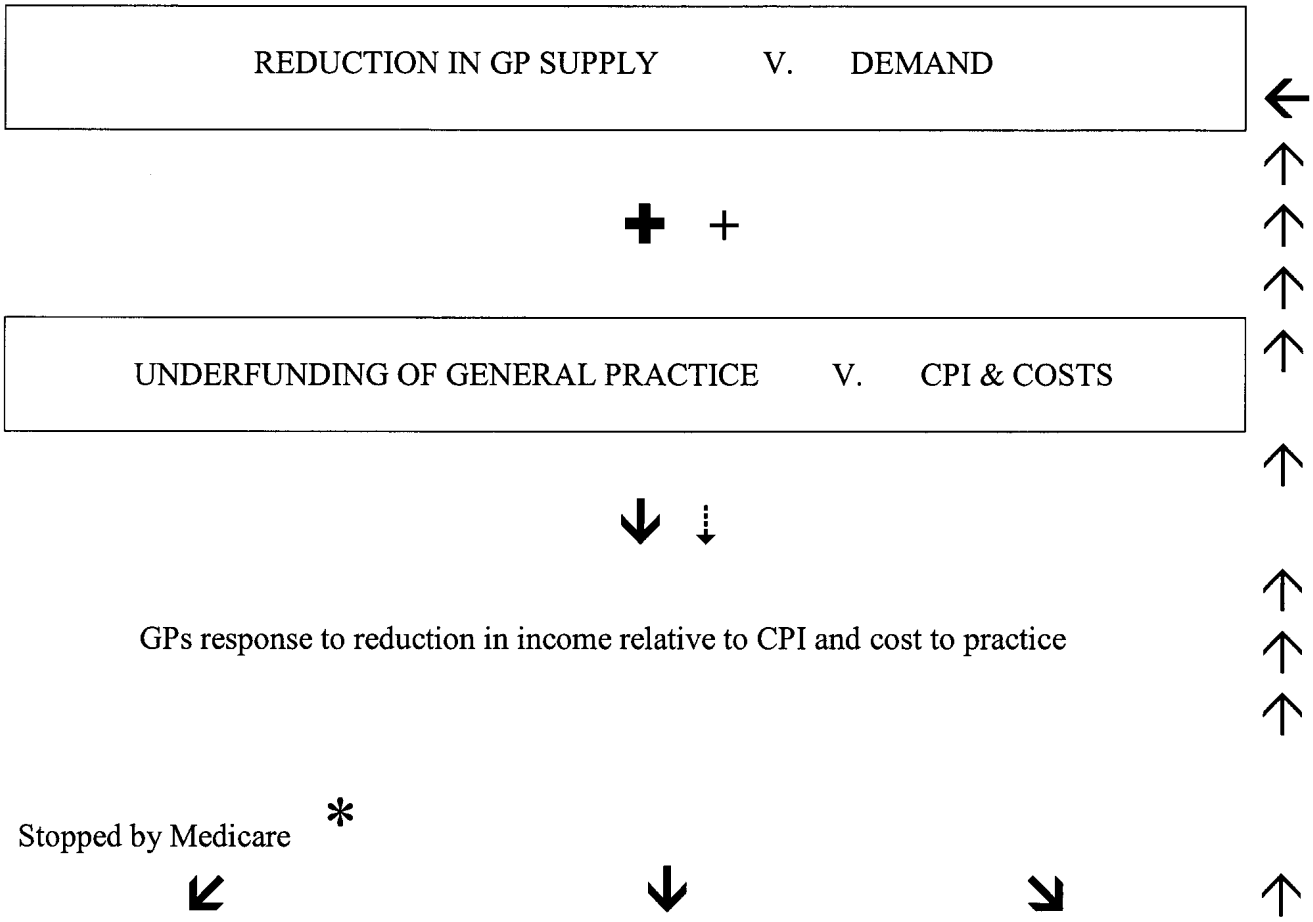
7 The ACT 2009-10 Budget Paper No 4, at page 216, records that of the $12.2m, only $1.5m is to be spent in 2009-10, and only a further $2.5m in 2010-11. The associated Media Release No 12 identifies the initiatives on which these paltry sums will be spent.

5. The mechanisms described in **Sections 1, 2 and 3** above that lead to the GP clinic closures and GP shortages can be summarised in the following diagram/model.



6. The longer these mechanisms are in place, the greater the need for general practitioners to consolidate (i.e. the greater the reduction in number of small practices).

7. An outcome of the above mechanisms will be a sudden increase in the cost of health care to patients. This will occur when the loss of the professional and financial benefits of consolidation fails to offset the causative factors.

Why is this Inquiry being conducted?

8. It is difficult to understand why this Inquiry is being conducted. The Inquiry's Terms of Reference cover the same territory that is covered by:

   (a) The in-depth annual reports on general practitioner supply, produced by the Australian Institute of Health and Welfare over the years since it was established by the Commonwealth Government in 1987.

   (b) The Australian Medical Workforce Advisory Committee's report "The General Practice Workforce in Australia – Supply Requirements 1999-2010", of 142 pages, published in August 2000.

   (c) The Australian Medical Workforce Advisory Committee's report "The General Practice Workforce in Australia – Supply Requirements to 2013", of 655 pages, published in August 2005.

   (d) The in-depth work of The National Health Workforce Taskforce, which is a specialist, well-funded body set up in 2006 by the Council of Australian Governments. Its most recent report "Health Workforce in Australia and Factors for Current Shortages", is of 73 pages, and was published in April 2009.

   (e) The numerous other reports that have been given, from 1996 to April 2009, to the Australian Health Ministers (which, of course, includes the ACT Minister for Health).

9. The Website of the National Health Workforce Taskforce is www.nhwt.gov.au. You can ring them on (03) 9092 2001. **Accompanying** is a 6 page list, from their Website, of just some of the numerous reports on the topic.

10. The Website of the Australian Institute of Health and Welfare is www.achw.gov.au. **Accompanying** is a list, from its website, of its 10 most recent reports (out of 71 reports that deal with general practitioners and other professions within the health labour force).

B. ROLE OF NURSE PRACTITIONERS AND OTHER HEALTH PROFFESIONALS IN PROVIDING PRIMARY HEALTH CARE

11. **General Practice** is comprehensive in scale and wide in scope of medical care provision. Its features include primary care of patients on a background of wide training of practitioners in the recognition and prevention of illness. Integral to the role of a good GP is the recognition of the normal, as much as the abnormal. Recognition of the sick and ill as distinct from patients who fear they are ill; or, in the alternative, think that they are well while they are not. The role of the general practitioner allows a relationship with the patient that allows the general practitioner the best position to introduce, encourage and seek preventative health care outcomes. Alternative health professionals are not able to replace these skill-sets and outcomes.

12. Other health care professionals – nurses, medical specialists, dieticians, physiotherapists etc - all have narrowly trained and defined skill-sets that are not transferable to the role of a general practitioner; or, to part of the role of a general practitioner. In addition, many of these other health care providers are even more specialised within their training (i.e. we have nurses who are theatre nurses, oncology nurses, O&G nurses etc).

"A little knowledge is a dangerous thing"

13. The use of nurse practitioners, and similarly narrowly trained staff, will increase the demand for care, with reduced positive outcomes. Nurses are trained and are aware of risks and negative outcomes. However, as nurses do not have the general practitioner training and skill-sets, the end result is an increase in referrals rather than less, and an increase in inappropriate referrals rather than appropriate referrals. Use of nurse phone triage systems, for example, will show no change in hospital admissions or attendances.

14. There is a significant benefits in the use of nurse practitioners and other ancillaries within a group of general practitioners **provided** this allows the GP to deal with increased numbers of patients.

15. For this to be effective, it is essential that Medicare's strategy of alleging "concerns" regarding numbers of patients cared for, be discontinued (see **para 2.7(g)** above).

16. Another issue is that ancillary health care providers are also in short supply, for not dissimilar reasons to those of general practitioners (under-funding, lack of training positions etc).

17. The increased recruitment of nurses into general practice, to bolster shortages in the capacity to manage demand, will simply lure nurses away from the acute sector, that is, hospitals. Government will then find that its hospitals are short-staffed and wonder why. Wages for nurses in hospitals will increase.

C. HOW TO ARREST, AND REVERSE, THE DECLINE IN GP NUMBERS

18. **To arrest the decline** in numbers of general practitioners, there needs to be a reversal for much of the foregoing. Steps that should be taken include:

(a) Train more general practitioners, but note that GPs starting university training today are not effective in the workforce for nearly a decade.

(b) Urgently increase funding for general practice and continue to increase funding for general practice in excess of the cost increases of practice and CPI increases.

(c) Free up general practitioners with the removal of all of restriction on provider numbers, and remove all barriers to overseas trained doctors from accepted and recognized universities (UK, SA, NZ, USA).

(d) Immediately allow all the current GP workforce to work to their preferred capacity rather than to Medicare directed limits.

(e) Consider changes in the training of general practitioners with some reduction in the university component and an increase in the "apprenticeship" practice training.

(f) Take away the benefits of GP "specialist clinics" (such as, skin cancer clinics, impotence clinics, cardiac clinics, etc) by making it a requirement of Medicare rebates eligibility that GPs provide at least 50% of their care in comprehensive general practice rather than so-called specialised practice.

(g) Tax "out of existence" the legal "ill-health" providers (alcohol and tobacco etc). Do this as a health care measure, together with a source of funding.

(h) Similarly, tax and police illegal drug industries and, where appropriate, "compete" with the illegal drug supplies by providing "free supplies and care" to patients.

(i) Reduce the government "red tape" that is unique to general practice.

(j) Eliminate anything that increases the cost of general practice in the ACT, compared to other regions in Australia. In particular, the only privacy legislation that should operate in the ACT should be the Privacy Act 1988 (Cth) and fees for access to patient records should be increased so that they are uniform with that in NSW.

(k) Provide appropriate incentives for general practitioners to practise in the ACT, as compared to other regions of Australia. In effect, the removal of disincentives in **para (j)** above and the giving of incentives, should be viewed as two levers which the ACT Government could use to attract practitioners to the ACT.

19. In summary:

(a) **Short term (effective in 0-3 years)**

(i) Allow current GP workforce to work to its capacity without Medicare hindrance.
(ii) "Free up" GP provider numbers.
(iii) Urgent increase in funding for general practice primary care.

(b) **Medium term** (a decade)

(i) Train more GPs, nurses and other health care providers.
(ii) Fund general practice in excess of CPI and cost increases.

(c) **Long term** (decades)

(i) Increase in birth rate.
(ii) Increase in young migrants.
(iii) Do nothing and wait for "ageing population" to "pass".

D. LINKAGES BETWEEN GOVERNMENT AND NON-GOVERNMENT HEALTH CARE PROVIDERS

20. The "linkages" commonly referred to are "e-health" initiatives, that is, electronic health records that are shared between all health care providers seen by the patient, whether in the public or private sector. While other "linkages" might also be considered, the comments below are restricted to the shared electronic record, that is, hospitals would have access to the electronic record maintained by the GP.

21. Such linkages are generally said to be of high priority by the government. This is on the basis that there would be "saving" in cost of health care provision and, in particular, there will be savings in "duplication" and reduction in admissions to hospitals and other high cost services.

22. There is little evidence to support the above. The value in achieving linkage is worth striving for, but one should not overstate the value.

23. The Primary Health Care Ltd group ("**Primary**") currently has systems that provide fully computerised medical records, and an ability to store and retrieve diagnostic and other images at any number of sites throughout Australia. These systems could be made available to third parties.

24. Primary's systems did not arrive "out of thin air". Those systems have come about by the investment by Primary of more than $100m, continued development of software and its implementation at the rate of $5m to $10m per annum together with not insignificant maintenance of software and hardware of these systems together with training of staff.

25. The ability to provide e-health connectivity with government and non-government providers is available. The issue is always said to be about "systems", "confidentiality" etc. These are reasons for deferral and non-implementation.

26. The Australian Health Ministers, on 28 January 2004, converted the National E-Health Transition Authority into a company and tasked it with "the urgent advancement of the e-health agenda." Over the 5 years since, not much has been achieved in practical implementation. Indeed, some trials have resulted in failures.

27. The real reason that nothing happens is there is no financial incentive for anything to happen. Given proper financial incentives, other issues will fall into place. There seems a concept that Primary, and other parties, should make available to third parties, at no cost, the infrastructure and systems that they have developed. This is a neither an attractive nor a reasonable option. Where there have been offers of payment for connectivity of various forms, it has been inevitably inadequate and inconsistent with the costs and the work involved. Vilification and various forms of "grandstanding" by politicians and governments leads one to a less than enthusiastic approach to cooperative outcomes, especially when there is so much alternative work to be done.

28. Assuming government did properly pay GPs for the very significant costs GPs incur in implementing e-health, there is some doubt as to whether any of the claimed economic benefits will emerge. For example, it is said that if a hospital had immediate access to the electronic record maintained by the GP then the doctor in the hospital would not need to repeat tests that have already been undertaken by the GP. This is highly unlikely. Apart from such tests being out of date, the reality is that the doctor in the hospital would be negligent not to make his or her own assessment, diagnosis, and order appropriate tests for the patient. Further, the purpose and quality of the notes (which will be variable) recorded in the electronic record by the GP will be such that, as a general rule, a doctor in a hospital will be unlikely to rely on them.

29. The ACT Budget, presented on 5 May 2009, provides for a $90m investment in e-health and infrastructure. Personal electronic health records, which are meant to allow for electronic sharing of patient clinical information between the hospital and the general practitioner, is a key feature of the initiative. This initiative will suffer from the same problems referred to above.

30. The ACT Health Minister will be undertaking a study tour to Denmark and Norway in August 2009. One of the key stated purposes of the tour is for the Minister to draw on the experience of the world's leaders in e-health.[8]

[8] Media Release 26 June 2009.

E. UNDERUTILISATION OF GPs IN THE A.C.T.

31. The ACT GP Taskforce Discussion Paper, "Issues and Challenges for General Practice and Primary Health Care", released on 19 June 2009, states at page 12:

> "Although data on how short the ACT is vary, the latest Report on Government Services 2009 states that the number of full-time workforce equivalent (FWE) GPs for 2007-2008 is:
>
> - Urban (Australia) – 90 GP FWE per 100,000 people
> - Rural (Australia) – 80 GP FWE per 100,000 people
> - ACT – 67.5 GP FWE per 100,000 people
>
> Based on this information the ACT needs 74 extra full-time GPs to reach the national average of GPs per head of population."

32. The more complete set of figures, derived from the Productivity Commission's Report referred to by the ACT GP Task force, is as follows for 2006-07:[9]

FWE GPs per 100,000 people

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST
Both Urban and Rural	94.1	84.7	85.4	71.4	89.5	79.2	66.8	48.3	86.1
Urban only	97.2	87.3	85.4	73.9	91.5	86.0	66.8	53.7	89.4

33. The "Medical Labour Force 2006" report of 69 pages published in October 2008 by the Australian Institute of Health and Welfare ("**AIHW**"), records the following in respect of 2006:

FTE GPs per 100,000 people

NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST
101	99	80	100	107	102	112	131	97

34. It should be noted that, based on the above, the ACT has the highest number of FTE GPs per 100,000 people of any region in Australia (except only for the Northern Territory).

[9] Tables 11A.3 and 11A.12 of Productivity Commission report.

35. The AIHW states in its "Medical Labour Force 2006" report that "full-time equivalent" or **FTE** is:

> "A measure of the workforce that takes into account both the absolute number of workers and the average hours per week that they work. In this report, 45 total hours per week is assumed to be equivalent to 1 FTE.
>
> The number of a full-time equivalent practitioners equals the number of practitioners multiplied by the average weekly hours worked, divided by the number of hours in a 'standard' full-time week, i.e. 45 hours for this report."

36. The FTE figure for each GP is capped at one. That is, a GP with 50% of the average billing for full-time GPs is counted as 0.5, while GPs billing at or above the average are counted as one.

37. Both the Productivity Commission and the AIHW state that "full-time workload equivalent" or **FWE** is calculated for each general practitioner by dividing the GP's Medicare billing by the mean billing of full-time practitioners for the reference period. For example, a FWE value of 2 indicates that the GP's total billing is twice that of the mean billing of a full-time GP. Calculating FWEs is a measure of medical workforce supply that takes into account the differing work patterns of GPs. There is no cap on a GP's FWE. That is, a GP with 50% of the average billing for full-time GPs is counted as 0.5, a GP billing at the average is counted as one, and a GP billing at 150% of the average is counted as 1.5.

38. Caution should be taken when comparing Medicare-based FWE and AIHW FTE figures. Nevertheless, in the case of the ACT some interesting observations can be made with respect to that comparison. From the tables in **paras 32 and 33** above the following is notable:

    (a) the 97.2 FWE GPs per 100,000 people for urban NSW is close to the 101 FTE GPs for NSW;

    (b) the 66.8 FWE GPs per 100,000 people for the ACT is very different from the 112 GP FTE GPs for the ACT.

39. One reasonable conclusion that might be drawn from that combination of the high FTE figure and the low FWE figure for the ACT is that, while there is a plentiful supply of full-time GPs in the ACT (compared to all other regions in Australia), the numbers of GPs in the ACT who are billing Medicare above the average billed by a full-time GP, is very low. The FTE calculation is capped (see **paras 35 and 36** above). The FWE calculation is uncapped (see **para 37** above).

40. In other words, a reasonable conclusion is that, unlike in say urban NSW, when the cap calculation is lifted there is no material increase evident from the full-time GPs in the ACT.

41. It may well be the case that full-time GPs in the ACT have a capacity to do more work, but for a variety of reason do not do so.

42. The above observations concerning the yawning gap between the low FWE and high FTE figures for the ACT may well tie in with the fact that the rate of bulk-billing by GPs in the ACT is the lowest for any region in Australia.

43. Medicare reports that, in respect of the 2006-07 year, the following percentages of Medicare services were bulk-billed.

NSW	VIC	QLD	WA	SA	TAS	ACT	NT	TOTAL
76.6	70.8	71.8	69.3	71.5	68.1	61.4	76.7	72.9

44. The bulk-billing rate in the ACT is the lowest of any region in Australia. It is some 25% lower than in NSW.

45. If GP services alone are looked at, the position in the ACT is 2006 was even worse than suggested above. Medicare reports that for calendar year 2006 the percentages of GP services bulk-billed were:

NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST
82.4	74.3	74.1	71.6	75.5	69.9	48.0	62.2	76.6

46. Another inference to be drawn from the commentary above is that full-time GPs in the ACT, more so than other regions in Australia, do more billing above the Medicare rebate level (which surplus the patient pays) and full-time GPs do not then work hours beyond a full-time level.

Survey of GPs in the ACT

47. It may be that a material number of GPs in the ACT already have the capacity to work materially longer hours than they do. The shortage of FWE GPs in the ACT may be cured by simply providing appropriate incentives for the existing GPs to work some additional hours.

48. Australia-wide, the percentage of GPs who work 50 hours or more per week dropped from 35.2% in 2002 to 27.9% in 2006[10]

49. The AIHW concludes, in respect of the supply of GPs in Major Cities of Australia:

"... over the same period [from 2002 to 2006] the supply of primary care clinicians decreased by 7 FTE per 100,000 to 98 FTE per 100,000 population in

[10] Table 10 in AIHW report "Medical Labour Force 2006."

2006. **This drop is largely a result of a decline in the average hours worked by primary care practitioners** [emphasis added] in this RA" [Major Cities][11]

50. The AIHW reports also that average hours per week worked by GPs are in 2006:

NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST
40.3	39.1	39.4	38.2	40.1	37.1	37.9	40.5	39.5

51. It should be noted that, based on the above, GPs in the ACT are working, on average, less hours than GPs in any other region of Australia (except only for Tasmania). Further, over the period 2002 to 2006 that average for the ACT has dropped from 40.5 to 37.9 hours per week, a drop of 6.9%.

[11] AIHW report "Medical Labour Force 2006" page 25.

working together for Australian health workforce reform

Reports, Publications and Newsletters

AHMC Publications

National Health Workforce Strategic Framework - April 2004 (pdf, 244k)

NHWT publications

The health workforce in Australia and factors influencing current shortages (pdf, 677k)

It is generally accepted that Australia will continue to experience increasing demand for health care workers and at a rate that will challenge Australia's training and service delivery systems' without significant change to it's approach to workforce development. The underlying health service demand drivers include; population growth, ageing of the population, changing nature of the burden of disease and greater focus on health prevention, which taken together with consumer and workforce expectations, combine to result in increasing demand for health care services and for healthcare workforce.

The current and projected shortage in the Australian health workforce are driven by a complex interaction of demographic, socio-cultural, clinical and professional factors that exert influences on both the demand for health workers' services, and the supply of health workers. These shortages are not uniformly distributed, but vary by health profession, specialty, jurisdiction and geographical location (metropolitan, rural, remote).

As part of developing the health workforce reform package for consideration of and subsequent agreement by COAG in November 2008, the National Health Workforce Taskforce commissioned KPMG to prepare an analysis that outlines the factors influencing current and projected workforce shortage and that considers the implications that these factors may have on workforce development strategies. This document provides a useful background and insight to the problems being faced.

Self Sufficiency and International Medical Graduates - Australia (pdf, 172k)

19 of 26

Clinical placements across Australia: capturing data and understanding demand and capacity (pdf, 408k)

Workforce innovation and reform: Caring for older people Discussion paper - December 2008 (pdf,684k)

Clinical training - Governance and Organisation Discussion paper (pdf, 424k)

Workforce Innovation and Reform Demonstration Projects national evaluation framework (pdf,156k)

Other Publications

The Australian Health Ministers' Advisory Council (AHMAC) undertook a review of its committees in 2005-06 resulting in the disbanding of a number of professions specific workforce committees to enable a more holistic, multidisciplinary approach to consideration of health related policy development and program review activity. This included the cessation of profession-focused committees such as the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC). The HWPC now coordinates all of AHMAC's workforce activity.

Reports produced by committees previously under the auspice of AHMAC and reports produced by the National Nursing and Nursing Education Taskforce (N3ET) are available below.

2006

Health workforce impact checklist (pdf file, 80k)

Health workforce planning in emergency departments (pdf file, 264k)

The Australian allied health workforce (pdf file, 435k)

The perioperative workforce in Australia (pdf file, 525k)

2005

A models of care approach to health workforce planning (pdf file, 169k)

AHWOC Annual Report 04-05 (pdf file, 194k)

Career decision making by postgraduate doctors - Key findings (pdf file, 66k)

Career decision making by postgraduate doctors - Main report (pdf file, 3327k)

Career decision making by postgraduate doctors - Statistical appendix (pdf file, 109k)

Career decision making by postgraduate doctors - Summary (pdf file, 185k)

Clinical Training Placements - Analysis of responses (pdf file, 65k)

Demand for health services and the health workforce (pdf file, 571k)

General practice workforce modelling - Technical paper (pdf file, 1354k)

Review of Australian specialist medical colleges (pdf file, 540k)

Technology and health workforce planning (pdf file, 644k)

The general practice workforce in Australia - Summary (pdf file, 245k)

The general practice workforce in Australia (pdf file, 3092k)

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2004

Australian nursing workforce - An overview of planning (pdf file, 220k)

National Health Workforce - Strategic Framework (pdf file, 254k)

Nursing workforce planning in Australia (pdf file, 524k)

Public hospital medical workforce in Australia - Appendices (pdf file, 1369k)

Public hospital medical workforce in Australia (pdf file, 614k)

Specialist obstetrics and gynaecology workforces in Australia (pdf file, 2735k)

Survey of doctors in rural and remote locations - OTD Scheme (pdf file, 680k)

Sustainable specialist services - A compendium of requirements (pdf file,

599k)

2003

AHWAC Annual Report 02-03 (pdf file, 155k)

Australian mental health nurse supply - Recruitment and Retention (pdf file, 880k)

Career decision making by doctors in vocational training - Review (pdf file, 191k)

Career decision making by doctors in vocational training - Survey (pdf file, 909k)

Emergency care workforce forum (pdf file, 187k)

Specialist medical workforce planning in Australia (pdf file, 472k)

The specialist emergency medical workforce in Australia (pdf file, 603k)

The specialist pathology workforce in Australia (pdf file, 690k)

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2002

Career decision making by doctors in postgraduate years (pdf file, 717k)

The critical care nurse workforce in Australia (pdf file, 2730k)

The midwifery workforce in Australia (pdf file, 4197k)

2001

The cardiothoracic surgery workforce in Australia (pdf file, 450k)

The specialist anaesthesia workforce in Australia (pdf file, 2235k)

The specialist medicine and haematological workforce in Australia (pdf file, 825k)

The specialist radiology workforce in Australia (pdf file, 491k)

2000

Medical workforce training and employment workshop (pdf file, 60k)

The general practice workforce in Australia (pdf file, 539k)

The neurosurgery workforce in Australia (pdf file, 402k)

The specialist gastroenterology workforce in Australia (pdf file, 507k)

The specialist thoracic medicine workforce in Australia (pdf file, 467k)

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1999

Temporary resident doctors in Australia (pdf file, 682k)

The consultant paediatric workforce in Australia (pdf file, 702k)

The intensive care workforce in Australia (pdf file, 413k)

The orthopaedic surgery workforce in Australia (pdf file, 254k)

The specialist cardiology workforce in Australia (pdf file, 529k)

The specialist psychiatry workforce in Australia (pdf file, 861k)

1998

Influences on participation in the Australian medical workforce (pdf file, 137k)

Medical workforce supply & demand in Australia - Discussion paper (pdf file, 351k)

New Zealand medical graduates in the Australian medical workforce (pdf file, 247k)

Sustainable specialist services - A compendium of requirements (pdf file, 702k)

The obstetrics and gynaecology workforce in Australia (pdf file, 734k)

The radiation oncology workforce in Australia (pdf file, 388k)

The specialist dermatology workforce in Australia (pdf file, 505k)

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1997

The characteristics of medical students entering medical schools (pdf file, 313k)

The ear nose and throat surgery workforce in Australia (pdf file, 379k)

The emergency medicine workforce in Australia (pdf file, 306k)

The general surgery workforce in Australia (pdf file, 394k)

The geriatric medical workforce in Australia (pdf file, 489k)

The rehabilitation medicine workforce in Australia (pdf file, 371k)

1996

Australian medical workforce benchmarks (pdf file, 158k)

Female participation in the Australian medical workforce (pdf file, 200k)

The anaesthetic workforce in Australia (pdf file, 389k)

The medical workforce in rural and remote Australia (pdf file, 332k)

The ophthalmology workforce in Australia (pdf file, 827k)

The orthopaedic surgery workforce in Australia (pdf file, 903k)

The Urology Workforce in Australia (pdf file, 605k)

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Australian Government
Australian Institute of Health and Welfare

Publication catalogue list

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Health and community services labour force 2006

National health labour force series no. 42

In 2006, over 9% of Australia's workforce was employed in health and community services occupations - a 26% increase from 2001. Between 2001 and 2006 the health workforce and community services workforce increased by 22.8% and 35.6% respectively. Over the same period, the health and community services workforce aged with the proportion of workers in the 55 to 64 years age bracket increasing by 4 percentage points. This report also contains information on geographical distribution, country of birth and qualifications held.

Authored by AIHW.

Published 6 March 2009; ISSN 1327-4309; ISBN-13 978 1 74024 891 4; AIHW cat. no. HWL 43; 80pp.; **$27.00**

Medical labour force 2006

National health labour force series no. 41

This report presents demographic and labour force statistics on the medical profession in Australia and trends in the number of employed doctors. It is based on the main findings of the 2006 national survey of registered medical practitioners. Information presented includes a national and state/territory overview of the number of medical practitioners (including age and sex, field of medicine, working hours and where they work), their geographic region and overall supply.

Authored by AIHW.

Published 31 October 2008; ISSN 1327-4309; ISBN-13 978 1 74024 836 5; AIHW cat. no. HWL 42; 80pp.; **$26.00**

Dental hygienist labour force in Australia, 2005

DSRU research report no. 34

Authored by AIHW Dental Statistics and Research Unit.

Published 7 August 2008; ISSN 1445-775X; AIHW cat. no. DEN 173; **INTERNET ONLY**

Dental labour force in Australia, 2005

DSRU research report no. 33

Authored by AIHW Dental Statistics and Research Unit.

Published 7 August 2008; ISSN 1445-775X; AIHW cat. no. DEN 172; **INTERNET ONLY**

Dental prosthetist labour force in Australia, 2005

DSRU research report no. 37

Authored by AIHW Dental Statistics and Research Unit.

Published 7 August 2008; ISSN 1445-775x; AIHW cat. no. DEN 184; 4pp.; **INTERNET ONLY**

Dental therapist labour force in Australia, 2005

DSRU research report no. 35

Authored by AIHW Dental Statistics and Research Unit.

Published 7 August 2008; ISSN 1445-775X; AIHW cat. no. DEN 174; **INTERNET ONLY**

Medical labour force 2005

National health labour force series no. 40

This report presents demographic and labour force statistics on the medical profession in Australia and trends in the number of employed doctors. It is based on the main findings of the 2005 national survey of registered medical practitioners. Information presented includes a national and state/territory overview of the number of medical practitioners, their geographic region and overall supply.

Authored by AIHW.

Published 18 January 2008; ISSN 1327-4309; ISBN-13 978 1 74024 748 1; AIHW cat. no. HWL 41; 56pp.; **$24.00**

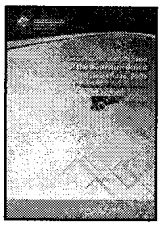
Nursing and midwifery labour force 2005

National health labour force series no. 39

This report presents statistics on trends in the employment of nurses and midwives in Australia. It is based on the main findings of the 2005 national survey of nursing and midwifery. Information presented includes a national and stat/territory overview of the number and characteristics of nurses and midwives, their geographic region and overall supply.

Authored by AIHW.

Published 18 January 2008; ISSN 1327-4309; ISBN-13 978 174 024 7443; AIHW cat. no. HWL 40; 68pp.; **OUT OF PRINT**



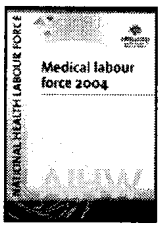
Geographic distribution of the Australian dental labour force, 2003

Dental statistics and research series no. 37

Geographic distribution of the Australian dental labour force 2003 presents results from the 2003 national dental labour force data collection. The collection includes all dentists, dental therapists, dental hygienists and dental prosthetists across Australia. This publication presents the overall numbers and the practice status of the dental labour force in each state and territory, across geographic remoteness regions and nationally. Other statistics describe the demographic distribution, area and type of practice and the usual hours worked per week of the four dental occupational groups. Where possible, the results are compared with those from previous dental labour force collections.

Authored by AIHW Dental Statistics and Research Unit.

Published 17 December 2007; ISSN 1321-0254; ISBN-13 978 1 74024 734 4; AIHW cat. no. DEN 168; 224pp.; **$24.00**



Medical labour force 2004

National health labour force series no. 38

This report presents demographic and labour force statistics on the medical profession in Australia and trends in the number of employed doctors. It is based on the main findings of the 2004 national survey of registered medical practitioners. Information presented includes a national and state/territory overview of the number of medical practitioners, their geographical region and overall supply.

Authored by AIHW.

Published 20 December 2006; ISSN 1327-4309; ISBN-13 978 1 74024 633 0; AIHW cat. no. HWL 39; 36pp.; **$22.00**

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